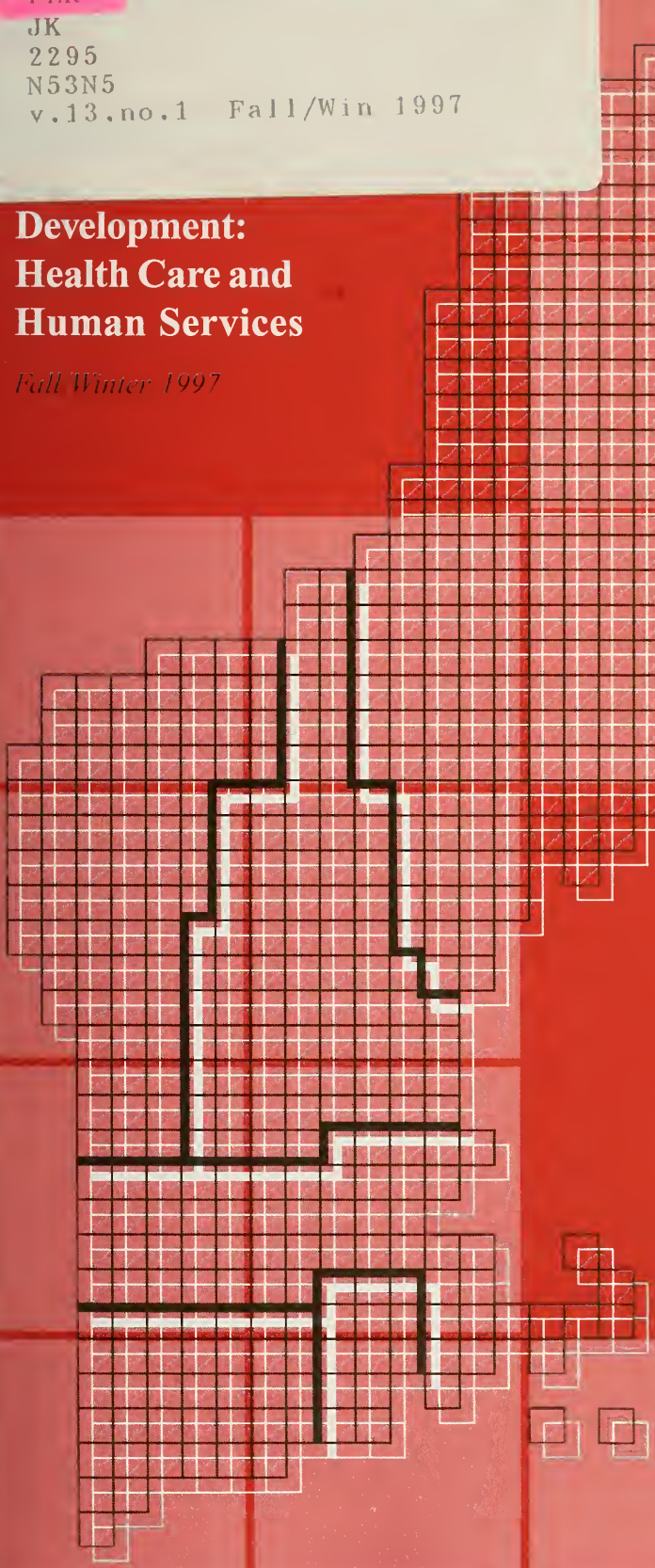
Development: Health Care and Human Services

Fall/Winter 1997



New England Journal of Public Policy

A Journal of the
John W. McCormack Institute
of Public Affairs
University of Massachusetts Boston

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New England Journal of Public Policy

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Workforce Development: Health Care and Human Services

Trends and Policies

Alternative Programs and Strategies

Editor's Note

Padraig O'Malley

We stealthily approach the end of the twentieth century, stealth stimulated in part by the metaphysical uneasiness that accompanies the anxious passage into a new era, one that transcends the bounds of our limited imaginations because we cannot grasp the imponderables of the advent not just of a new century, but of a new millennium. The word itself conjures up the fears that lurk in our subconscious as we attempt to placate our anxieties of an uncertain future with the anticipation of the challenges that lie ahead. We are not attuned to concepts of millennia for, like the galaxies suspended in the infinity of space, they suggest enigmas beyond the mysterious, intimations of mortality, and the perils of our own deceitfulness in the face of our inevitable demise.

On the broad horizon of redefinition: the meaning of the word *globalization,* especially a globalization that is accompanied by the phenomenon of increasing fragmentation; the diseconomies of production and consumption that cross national frontiers; the implosion of environmental disorders that threaten the coordinates of nature; the questioning of traditional concepts of sovereignty in a world of saturated interdependence; the alarming disposition on the part of that slice of the world we call developed to make the poor countries the payees for the excesses of the rich; the inexorable proliferation of the arms industry and the increasing threats of nuclear joyriding; the free-floating gymnastics of the so-called free markets spreading the miasma of their "circuit breakers," whose primary function, it would appear, is to protect investors from the very risks to which the market is supposed to expose them.

On the more narrow horizon of definition: the meaning of work; the availability of work; the catastrophic impact of downsizing on ordinary men and women who find that their ability to adjust to the demands of a valueless world order falls short of the imperatives that are invoked to justify that order; the shallow genuflections to the new gods of the international order; the new commandments of the unbridled greed of multinational corporatism promulgated in the name of peace and prosperity; technology and web sites elevated to the theological canons of quasi-secular religions; religion robbed of its vestiges of holiness in the name of dubious moralities; morality shorn of its spirituality; spirituality stripped of its humanity; humanity besmirched of its dignity when it is denied its fundamental essence — to till the fields, wield the plow, wipe the sweat off its brow, and heal the sick.

Hence my rather apoplectic introduction to this special issue of the *New England Journal of Public Policy,* an introduction that wants you, the reader, to begin to connect what might appear to be the almost hypothetical changes on the far-flung abysses of the cosmic frontiers of the future with the incremental changes that define the rhythms of

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our daily lives. For the ineluctable fact is that as we cross the fault lines between the society we live in and the society we are about to inherit, we have become increasingly disposed to marginalize people, to consign them a utility that neither acknowledges their potential nor embraces their shortcomings. Left betwixt and between, they have become pawns in a creed of financial promiscuity in which the rich grow richer, the poor poorer, the hapless more hapless, the desperate more desperate, the detritus of our societies part of a disposable humanity, and the distribution of income both within developed countries and among developed and underdeveloped countries more ominously disproportionate than ever.

In recent years, a profusion of studies, both here in the United States and in the advanced postindustrial economies, reflects increasing disparities with regard to income, asset holdings, occupational structures, and educational levels, to mention just some of a number of variables among the upper and lower cohorts of society, disparities that are even more pronounced when considerations of race and ethnicity are taken into account. Rather than differences becoming less acute, despite the plethora of laws, affirmative action programs, social consciousness programs, advocacy groups, and the best-intentioned endeavors of dedicated nongovernmental organizations, they are becoming more acute. The "lowers" are not just not keeping their heads above water, they are slowly going under, the drowning gurgles of their desperate cries submerged in the voiceless chorus of silent impotence.

Who, for example, remembers central Los Angeles, that once inglorious symbol of what had gone awry with the American Dream? The ingloriousness remains — if as much money had been pumped into its economy and the rebuilding of its dilapidated and antiquated infrastructure as was poured into the voluminous, endlessly philanthropic studies that purported to identify its problems and the causes of its endemic social unrest (lo and behold, they discovered poverty!), central LA would reverberate today with the engines of renewal, not with the brays of betrayal.

My point is this: if, despite the resources at the disposal of this country, which prides itself on being the richest and most prosperous in the world, mere dents in the degree of racial inequality are the result, how are the subsistence countries of Africa, wracked by racial and ethnic problems, many of which are the making of their former colonial masters, ever to get out of the starting gate, especially when the affluent West has pulled the starting gate from under their feet? Or to pose the question in a slightly different form: In a global economy, what are our obligations not only to our own disadvantaged, but to the disadvantaged of the truly disadvantaged countries of the world, made more disadvantaged by global trade policies that work for the most part to our advantage?

Which brings me to this special issue of the journal, "Workforce Development: Health Care and Human Services," an issue that focuses on a range of problems in the health care and human service fields from a perspective that is, to say the least, frequently neglected in public policy discussion — the perspective of their workforces and the labor organizations that represent them. In many respects, the questions the articles address are a microcosm of the problems that will daunt us in the future, daunt us even more because, in a world of limited choices, denial has a special utility: by allowing us to evoke the unpalatable, it allows us to postpone the inevitable, and in a society that measures the long run in terms of the length of a football season, kicking for safety is invariably preferable to moving the goal posts.

The workers and organizations that form the core of the articles in this issue are at the cutting edge of the cosmic changes and the incremental changes to which I have

alluded. They embody the most far-reaching transformations in technology, the organization of work, the definition of service, the changing nature of the services themselves, the practices of corporate governance, the tensions between social responsibility and more narrowly defined shareholder interests, a redefinition of the roles and responsibilities of the various stakeholders, applications of standards of transparency and accountability, the common interests of management and workers in the management of change, issues of race, gender, and equity, and balancing interests of the public good against market-driven concepts of private entitlement.

In their Foreword, guest editors Andrés Torres and James Green encapsulate the essence of the issue. These articles, they write, "center on health care and human service workers in Massachusetts who, like their counterparts in other states, are experiencing various pressures resulting from the privatization and deinstitutionalization of public facilities, the downsizing and merging of private and public health care facilities, the growth of new forms of health care and human service delivery, including that administered by home-based and community-based providers, along with the spread of part-time employment in all fields, the growth of new technologies and the limits of job-training, as well as the impact of managed care and other cost-cutting measures. To many of these workers and their advocates, such pressures have created a crisis in the health care and human service fields."

Not to belabor the point: what is happening in the health care and human service delivery sectors of the economy is symptomatic only of the changes that are occurring or are going to occur in all sectors of the economy — some the product of "pull," as new technologies and the supply of new skills redefine the contours of the market, some the product of "push," as changes in the global economy have a ripple effect and new demands redefine the contours of the market. What is happening in the health care and related service industries is a microcosm of the nature of change itself, more than ever the embodiment of Joseph Schumpeter's concept of "creative destruction."

As we tentatively approach the millennium, our trepidation tempered by our innate optimism, our task is to find ways to encourage the creative while minimizing its destructive impact, all the time aware that we will fail as a society, as a nation of societies, if we lose sight of the fact that the maximization of human worth is the sine qua non of existence. That, or an Orwellian millennium.

Lest we forget: in the end, the cosmic is the sum of the incrementals.

Foreword

Andrés Torres
James Green

Many important debates about public policy at the national level and in states like Massachusetts have centered on health care and human services, including welfare and the care of children, the abused, the disabled, the elderly, and those suffering from mental and physical illness. In this issue scholars and advocates examine a range of problems in the health care and human service fields from a perspective often lacking in the public policy discussion — that of the workforce and of the labor organizations that represent the workforce.

This special issue is the product of research and advocacy work sponsored by the Labor Resource Center at the University of Massachusetts Boston's College of Public and Community Service. The articles by Andrés Torres, Françoise Carré, Maria Estela Carrión, James Green, Kathryn Cauble, and Enid Eckstein are derived from research projects conducted at the center with the support of the Ford Foundation and the John W. McCormack Institute for Public Affairs, University of Massachusetts Boston.

As a result, most of the articles center on health care and human service workers in Massachusetts who, like their counterparts in other states, are experiencing various pressures resulting from the privatization and deinstitutionalization of public facilities, the downsizing and merging of private and public health care facilities, the growth of new forms of health care and human service delivery, including that administered by home-based and community-based providers, along with the spread of part-time employment in all fields, the growth of new technologies and the limits of job training, as well as the impact of managed care and other cost-cutting measures. To many of these workers and their advocates such pressures have created a crisis in the health care and human service fields.

Public policy in health and human services is usually shaped by the concern of taxpayers, the agendas of policymakers and funders, and the interests of consumers and their advocates who, in some cases, have argued that the quality of care depends greatly on the quality of the environment experienced by direct-care workers. Yet, with all the policy changes, cost-cutting measures, and management innovations, health care and human service workers often feel left out of the policy debates and program development and believe that they are unfairly blamed for rising costs and decreasing consumer satisfaction. The research articles explore the world of these workers, examine the crises they have experienced in the workplace, and explore alternative ways of improving services while improving their quality of work life.

The studies of Carré, Carrión, and Lin Zhan and Jane Cloutterbuck analyze the impact of workplace transformation on various health care workers — entry-level employees, allied health professionals, and nurses. They examine a number of problems.

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Carrión identifies the lack of training and advancement possibilities for entry-level health care workers, especially women of color, and investigates the conflict and tensions they experience in relation to race, ethnicity, and gender. Carré explains that while opportunities do exist in higher-paid professional slots, they are only for well-trained workers. University of Massachusetts Boston Nursing School professors Zhan and Cloutterbuck focus on nurses and the many pressures on their profession brought about by health care restructuring, cost cutting, and managed care systems; they also investigate necessary changes in education and career development, arguing that nurses must be proactive at many levels, including the formation of public policy and the diversification of their profession.

Nurses, as the most unionized sector of the health care workforce, have been able to make some organized, collective responses to the pressures on their profession and to the challenges of public policy. More generally, Enid Eckstein of the AFL-CIO reviews the ways in which unionized health care workers can respond to workplace change and health care reform and how they can organize to make an impact on public policy. She maintains that workers must have a role in negotiating and bargaining over job redesign, which is usually entirely driven by management imperatives. She also makes a strong case for the involvement of organized health care workers in enhancing the quality of health care.

Torres, a College of Public and Community Service economist, analyzes an educational program initiated by the Service Employees International Union Local 285, which represents Massachusetts health care workers. The local's efforts produced a labor-management Workers Education Program (WEP) designed to improve opportunity and occupational mobility for entry-level hospital workers. It is noteworthy that the WEP experiment was begun because of supportive public policy that created a fund for the training and development of health care workers. Unfortunately, this promising venture was not institutionalized because management balked at making a long-term commitment, but the program offered an important example of how an organized workforce can take the initiative in responding to change and improving the skills of direct-care workers.

Other alternative programs and strategies, based on critiques of existing public policies and current practices, are analyzed in these pages. Lande Ajose, an MIT doctoral student, shows how welfare reform in Massachusetts directed former recipients into home health care jobs, but explains that many of them lack training for such work and that, in any case, occupational mobility is so rare in this field that some poor people who received public assistance earned wages that kept them mired in poverty.

Ruth Glasser and Jeremy Brecher report on an inspiring example of home health care aides who work with and for a South Bronx cooperative enterprise. Although wages are low, the workers, mainly women of color, are receiving training, acquiring competence, and gaining self-confidence in this "democratic, employee-owned company." Like other articles in this special issue, the study of Cooperative Home Care Associates indicates that the expanding need for certain kinds of direct-care workers in health and human services provides new opportunities for poor people. But the authors also posit that the opportunities require significant investment in the development of this workforce as well as the recognition that poor, disadvantaged people can improve themselves if they achieve enough control over their working lives. Glasser and Brecher show how self-help and mutual aid flourished through a cooperative way of organizing an agency.

Anna-Marie Madison, director of the College of Public and Community Service

Master's Program in Human Services, makes a parallel argument about the need for "mission-based" performance evaluation in which those who provide human services are involved in designing and carrying out the appraisal. Many human service providers find that outside funders and regulatory agencies, rather than those who are responsible for carrying out the agencies' missions, are driving the evaluation process.

Madison's analysis of mission-based performance evaluation is concerned mainly with small, nonprofit agencies in which unions are rare. In unionized human service agencies, including many public institutions, workers negotiate concerning conditions and procedures and are often able to respond to evaluations so that their voices can be heard. With the privatization of many state-funded human services, the unionized sector has declined and public employee unions have turned to organizing the privately employed workers, for example, the direct-care workers in Massachusetts group homes for the mentally ill and mentally disabled.

Edwin Meléndez, an economist and director of the Mauricio Gastón Institute for Latino Development and Public Policy, University of Massachusetts Boston, describes changes in the nation's employment and training systems. The effectiveness of workforce development policies and programs has been the subject of wide-ranging debate since the early 1990s. Meléndez evaluates current proposals for the revision of existing job training and placement strategies, with particular emphasis on the future role of community-based organizations and higher education institutions in training adults.

James Green, a coordinator of the Labor Research Center, describes an attempt by one union to reach out to providers in the group homes to form a partnership that would overcome traditionally adversarial labor-management relations. Low-paid direct-care workers would benefit from union wages and working conditions as well as improved training, while smaller providers would benefit from cooperation with other suppliers and the union, which would use its political influence to gain better funding for private workers' salaries. The union also proposed more flexible methods of disciplining workers and more cooperative methods of enhancing the overall effectiveness of the agencies in serving its clients. The article concludes with a call for public policies in health care and human service workers similar to the federal labor policies of the New Deal era, which allowed industrial workers to improve their wages and working conditions and to intensify their citizenship and self-image through collective bargaining and government regulation.

In sum, the research articles in this collection all point to the importance of health care and human service workers themselves as stakeholders in the development and implementation of public policy and in the provision of services. The contributors accept the inevitability of change in both fields, but they also recommend policies and practices that upgrade and empower these workers and assert that without such improvements, clients, consumers, and patients will not receive the excellent quality of care they deserve.

Nursing

A New Day, A New Way

Lin Zhan, Ph.D., R.N.
Jane Cloutterbuck, Ph.D., R.N.

The U.S. health care environment is changing rapidly. Its structure, financing, and delivery are being reconfigured toward an integrated system based on managed care. Increasingly, national interest in health promotion and disease prevention is moving care away from a disease-oriented, institutionally based model to a population-focused, wellness-oriented, and community-based system. Health care consumers are diversifying in age, ethnicity, and socioeconomic status. The approach emerging from these changes and others requires nursing to rethink, redesign, and retool its workforce to meet new challenges. This article analyzes nursing education, practice, and operations. The authors discuss the dilemmas and complexity of developing an effective nursing workforce and identify exemplary changes in other states. They suggest differentiated practice models, educational mobility, increasing representation of ethnic minorities, redevelopment of the nursing workforce, and access to nursing services.

The nation's health care system, driven by (1) reconfiguration of the structure, financing, and delivery of health care, (2) alterations in patterns of health and illness, and (3) demographic diversification within the population, is undergoing fundamental transformation. These trends have a significant impact on education and practice in the health professions. Nursing is no exception. Within a rapidly changing environment, nursing must reform its education, recalibrate its practice, and redesign its workforce to contribute uniquely to high-quality, cost-effective care for the general public. We address the dilemmas and complexity of developing a nursing workforce best suited to practice in an evolving and uncertain future. We identify exemplary changes occurring in other states that might benefit Massachusetts during this time of transition and contend that change involves both opportunity and chaos. A new paradigm requires new solutions.

Lin Zhan, assistant professor, College of Nursing, University of Massachusetts Boston, and director of council affairs, National League for Nursing, New York, conducts research and teaches gerontology, pathophysiology, and adult and community health nursing. Jane Cloutterbuck, associate professor, College of Nursing, University of Massachusetts Boston, conducts research and teaches gerontology and community health nursing.

For years our nation's health care system focused on acute illness, placing emphasis on providing institutional services at extraordinary costs. Today, the total cost of illness equals nearly 18 percent of the gross national product.[1] The sophisticated technology used to diagnose and treat acute illness has benefited millions of Americans, yet it has outstripped society's ability to pay for such care, leaving nearly 43 million Americans without health insurance or access to basic health care, and the number is growing. Spiraling health care costs have resulted in considerable pressure from the public and private sectors for cost containment. Buyers — government, employer, and individual — are moving away from the traditional health care system into managed care, a more cost-effective model.[2] Almost two of every three privately insured Americans are enrolled in a form of managed care.[3]

While there is no consensus with respect to an organizational structure for managed care, its underlying financial concept is to control costs and redistribute financial risks. Managed care providers, who are paid a fixed amount per member, assume responsibility for financial risks for all services covered under a capitated contract. Service delivery in managed care organizations emphasizes primary and preventive care, while coordinating the entire continuum of care "from health promotion and disease prevention to primary and secondary acute care, tertiary care, and long-term care . . . across episodes of illness and pathways of wellness."[4] Within this broadly configured system, individuals, families, groups, and populations are targeted for services, and individuals are held responsible for their own care. Managed care organizations are accountable for consumer satisfaction, cost reduction, and quality of treatment. The shift into managed care has created a new ground for the corporate sector. Home care, free-standing emergency care, and health maintenance organizations (HMOs) are being targeted. Investor-owned chains, growing swiftly, have gained more than 15 percent of the market in the past five years, a figure that is likely to double in the next five.[5] In theory, the integration of health care across the continuum of services appears to be an efficient approach to providing quality, cost-effective care. The goal of managed care may not be, however, to improve patient care, but to improve the system's competitive posture "by maximizing revenue and decreasing expense to generate profit that can be used for new expansion . . . or to provide a return on investment."[6]

The emerging paradigm of health care is also responding to changing patterns of health and illness within the population. In the early twentieth century, the greatest risk for morbidity and mortality was from acute and communicable diseases. Currently, a myriad of chronic illnesses such as hypertension, stroke, chronic lung disease, AIDS, substance abuse, and long-term mental disability pose the greatest threat. Almost half the U.S. population suffers from chronic illness, with nearly 40 million afflicted by more than one. Their ailments increase the number of persons who use health care services and intensify the usage of each. Changing patterns of health and illness give rise to concerns, since seventy-six cents of every U.S. dollar is spent on direct medical treatment of recurring complaints,[7] which consumed 30 percent of national health funds and 50 percent of the federal health budget in 1989.[8] Using the acute-care model to manage chronicity is ineffectual and costly. By and large, the chronically ill need long-term management of their illnesses in the community, within the context of their daily lives, and the demand for care will expand greatly.

U.S. demographics are changing. The percentage of persons aged sixty-five and over has increased from 4 percent in 1900 to 13 percent of the total population, and it is projected that by the year 2030, that figure will be 23 percent and almost half the

elderly will be seventy-five or older. The most dramatic growth is expected to occur between 2010 and 2030, when the 70 million World War II baby boomers begin to reach sixty-five.[9] The elderly comprise 14.1 percent of the total Massachusetts population, the tenth highest percentage in the nation, a figure projected to grow to 22.1 percent by 2050.[10] The fastest growing cohort of the elderly is the "oldest-old," who are eighty-five and over. This group is projected to grow from 3.3 million in 1994 to more than 19 million by 2050.[11] Moreover, older minorities are growing faster than their white counterparts. In 1980, for example, about 10 percent of all persons sixty-five and older were nonwhite. Ethnic minority elders presently comprise 14 percent of the population, projected to be 32 percent nonwhite by 2050.[12] Eighty-five percent of older adults have one or more chronic illnesses that require care over time.[13] The increasing aged and ailing population will add unprecedented demands for health services in community and long-term-care facilities.

Our nation is also becoming increasingly multicultural, multiethnic, and socioeconomically stratified. In 1990 the predominant minority population was 12 percent black, 9 percent Hispanic, 3 percent Asian, and 0.7 percent Native American. It is predicted that by 2050 blacks will have increased to 16 percent, Hispanics to 22 percent, and Asians to 10 percent.[14] Minority populations suffer disparities in health in comparison with whites. *The Report of the Secretary's Task Force on Black and Minority Health* found that black Americans suffered nearly 60,000 excess deaths per year in 1979–1980.[15] While a host of factors — socioeconomic, genetic, cultural, and institutional — determines an individual's health, poverty or near poverty, lack of access to health services, culturally inappropriate and insensitive care underlie many of the health problems of minority groups.[16] Health care organizations are called upon to develop culturally and ethnically appropriate services and to recruit a workforce that reflects the changing U.S. demography.

Altering the way health care is structured, financed, and delivered in patterns of health and illness and in population and demographic diversification exerts enormous pressure on health professionals' education and practice, and workforce patterning includes nursing. We raise two critical questions. Do the present nursing education system and workforce capability meet the demands of the emerging health care market? What mechanisms must be put into place to reform the educational system and to redevelop and redeploy members of the current nursing workforce to meet the challenges?

Nursing Workforce

The 2.2 million U.S. nurses form the single largest group within the health care professions.[17] Their participation in the labor force is nearly 80 percent, a rate higher than most job categories dominated by women. Ninety-seven percent of all nurses, whose median age is forty-four, are female and white. To enter professional nursing practice, they must acquire registered nurse licensure, an R.N., through a legal process that provides a mechanism for determining minimal competency of practitioners and for protecting the public health, safety, and welfare. Licensure is granted on a state-by-state basis by individual state boards of nursing. Basic eligibility to take the licensing examination, offered by the National Council of Licensure Examinations for Registered Nurses, is graduation from a state-approved school of nursing.

U.S. registered nurses deliver many essential health services in a variety of settings — hospitals, nursing homes, schools, home care agencies, the workplace, community

and rural health clinics, long-term-care facilities, and managed care organizations. Most R.N.'s are prepared as generalists, but the field encompasses an array of specialties that range from critical care, school nursing, occupational health nursing, pediatric nursing, community health nursing, and geriatric nursing to advanced practice in nursing. Nurses are also prepared in administration, research, and education. In 1992 about 495,500 R.N.'s had formal preparation as advanced nurse practitioners, 66 percent from certified programs and 31 percent from master's degree programs. More recently, advanced practice nurses (APNs) have acquired their education at the master's level. Of all nurses with advanced practitioner preparation, about three-quarters were providing patient care in primary care settings. They offer a broad array of services, including health assessment, treatment of common acute illness and injuries, and patient education and counseling in health promotion and disease prevention practice.

Massachusetts general law authorizes its board of nursing both to define advanced roles for nurses and to determine their eligibility for those roles. Like other states, the Massachusetts Board of Registration in Nursing recognizes and regulates such APN categories as nurse practitioners, nurse midwives, nurse anesthetists, and psychiatric/mental health clinical specialists. Within nursing, there is an escalating debate regarding the educational preparation of APNs and whether additional regulation is necessary.[18] As the health care delivery system continues its transformation, the demand for more highly educated nurses will increase. The emerging integrated managed care provides a relatively unstructured practice environment that requires nurses to possess a high degree of flexibility, independent professional judgment, critical thinking and problem solving abilities, and skills in managing care. To ensure a sufficient pool, the American Nurses Association calls for more federal funding for clinical education at the postgraduate level for advanced practice nurses.[19]

Where do nurses work? Distribution patterns in 1988 showed that more than two-thirds of all R.N.'s worked in hospital settings, about 7 percent each in nursing homes, community or public health settings, and ambulatory sites, and the remaining 11 percent in nursing education, student health, occupational therapy, and private-duty nursing.[20] A concentration of nurses in hospitals began in the early 1920s and started to skyrocket in the late 1960s. Two important trends over the past three decades have influenced the need for more nurses in hospitals. First, Medicare and Medicaid amendments to the Social Security Act of 1935 increased insurance coverage for millions of Americans.[21] Patients' ability to pay for care resulted in a huge expansion of hospital beds. Second, the rapid development of sophisticated medical technology after World War II has greatly intensified the need for nurses. For example, hospitals across the nation, which employed 50 nurses per 100 patients in 1972, employed 98 nurses per 100 patients in 1990.[22]

Placement of the nursing workforce primarily in hospitals is being challenged. The health care landscape is changing. Services are shifting from acute-care hospitals toward ambulatory and community settings to create a less expensive and more comprehensive system. Changing insurance reimbursement mechanisms now reward shorter lengths of hospital stays, and patients are being discharged at earlier stages of recovery than previously. More and more, advanced technology allows critically ill patients to receive care at home, and acute-care hospitals are fast becoming intensive care units. Hospital occupancy rates have decreased,[23] nurses have not been recruited to positions vacated by resignations and retirement, and some have been laid off.[24] Decreasing staff has affected all levels of nurses, including those in advanced practice.[25] It is expected

that downsizing, merging, and closing at least half the nation's hospital beds by the year 2000 will generate a surplus of 200,000 to 300,000 R.N.'s across the country.[26] Opportunities for employment reflect this trend. New graduates are having difficulty finding employment in traditional acute-care hospital settings, particularly in New England.[27] R.N.'s nationally are being displaced from their positions.[28]

Can the 200,000 to 300,000 "surplus" of R.N.'s predicted by the Pew Health Professions Commission be justified? The answer, not really. First, it is based on a traditional acute-care hospital market, using measurements such as budgeted vacancies. Second, it fails to identify specific factors in an analysis of the match between health care needs and workforce demands.[29] The central issue is not whether there will be a surplus of nurses but a question of how to retool and redeploy acute-care hospital nurses to serve the requirements of the emerging market.

Expansion of health care services into ambulatory and community-based settings will call for nurses who are prepared to deliver services at these sites, thereby adding to the overall demand for R.N.'s. This trend is under way. Between 1984 and 1988, the number of nurses employed in ambulatory care settings increased, and home visits covered by Medicare rose by 57 percent between 1980 and 1987.[30] Shorter hospital stays, with subsequent calls for home care, also increase the demand for nurses. Many new R.N.'s will practice in such community settings as nursing centers, health centers, schools, and HMOs.[31] Federal estimates indicate that the number of R.N.'s with bachelor's degrees, who are best prepared to work outside of hospital settings, will fall about 578,000 short of the demand by 2000.[32]

A shifting workforce redefines nurses' roles. In the near future, home health care, community-based agencies, and managed care organizations will comprise the largest market for R.N.'s. Until recently, visiting nurse associations dominated the home care market, providing nonacute care, and a nursing model and values predominated. As the home care industry has grown, so has its changing market share. Large corporations, including hospital chains and suppliers of health care products and services for the home, are aggressively pursuing their piece of the pie. The introduction of high technologies and high-tech therapies in community and home settings is challenging the traditional approach to nursing.

Demands of the emerging market will profoundly change nursing education, nursing workforce design, and nursing service delivery. Retooling the present nursing workforce while preparing students as future practitioners is critical. As nurses become displaced from jobs in acute-care hospitals and other institutions, the American Nurses Association recommends that they be eligible for dislocated worker programs and be reeducated to enter the budding health care market.[33] Redevelopment requires preparation of nurses in the areas of (1) critical care, as hospitals are becoming huge, high-tech, intensive-care units, (2) geriatric care, as U.S. residents are graying and living with chronic illnesses, (3) community health care, as the delivery system is deinstitutionalized and primary care is expanded into ambulatory and community-based settings, and (4) population-based care as the nation refocuses on health promotion and disease prevention within a diversified population. Are students and R.N.'s being educated to meet these demands?

Basic Nursing Education

Unlike the single route of other health professions, preparing nurses can be accomplished through multiple educational models. Study programs vary in length and provide diverse credentials. Regardless of program type, all graduates take the same licensing examination, which measures "minimal safe practice," and candidates who succeed become licensed. The three basic routes to qualification are associate degree, hospital-based diploma, and baccalaureate degree programs. Between 1993 and 1994, 94,870 graduates completed basic R.N. programs nationally. Among them, 28,912 (30 percent) were in baccalaureate degree programs, 58,839 (62 percent) in associate degree programs, and 7,119 (8 percent) in diploma programs.[34] Massachusetts has 41 basic nursing programs: 13 baccalaureate degree, 21 associate degree, and 7 diploma.[35] Between 1993 and 1994, 1,203 (41 percent) graduated from Bachelor of Science in Nursing (B.S.N.) programs, including 33 percent who were licensed as R.N.'s, 379 (13 percent) from diploma programs, and 1,346 (46 percent) from associate degree in nursing (A.D.N.) programs.[36]

The model of multiple entry and exit points in nursing education has evolved over time. Prior to the Great Depression, nursing, perceived as a vocation, emphasized skill acquisition and adherence to traditional values and norms. Later in the 1930s, more formal early education in nursing developed as an apprenticeship model. Hospital-based diploma programs, three years in length, are the present exemplars of such training. During World War II, a significant portion of this type of nursing education was financed by the federal government.[37] The late 1940s saw the development of a trend toward college education, the goal being to establish standard curricula for nurses to protect them from the potentially self-serving interests of hospitals, for which students were the primary source of cheap labor.[38] This trend was further reinforced by the advocacy of educational reformer Lucille Brown for moving nursing courses into institutions of higher education.[39] The first bachelor's degree program was offered at Boston University in 1948, marking the beginning of decline in hospital-based diploma programs, from 90 percent in 1948 to about the present 10 percent.[40]

This coincided with the growth of two-year junior college education, namely, associate degree programs.

Establishment of A.D.N. programs during the post–World War II era was partially an effort to meet society's need for and to respond to an ongoing nurse shortage. The A.D.N. level, similar to the model used by the U.S. Cadet Nurse Corps to train nurses during the war, was based on the premise that they could be prepared in less than three years and emphasized technical skills in patient care. A.D.N. programs mushroomed from the 1960s through the 1980s as hospital beds expanded; the ensuing demand for more nurses was filled primarily from graduates of those programs.[41] In Massachusetts, for example, the programs increased from 6 percent to 19 percent between 1968 and 1978. Since they were shorter, usually two years, and less costly, they presented an educational alternative for nontraditional students, including minorities, older students, male students, and low-income groups. Today, 57 percent of all R.N. education programs at the associate degree level[42] produce the majority of the nursing workforce.[43]

B.S.N. programs offer a baccalaureate degree. The first two years are devoted to general educational courses including natural sciences, social sciences, and humanities. Building on this foundation, the following two years are devoted to nursing theory and

practice across a human life span. With experience, B.S.N. graduates are prepared to assume leadership and responsibility for care in a variety of settings and possess a nascent understanding of the effect of nursing research on patient care. They are eligible to enter graduate programs at the master's and later the doctoral level, which prepare them for positions as researchers, administrators, teachers, and expert clinicians. B.S.N. programs now account for about one-third of the programs nationally.[44]

Demands of the changing health care system have already affected enrollment in nursing education. A.D.N. enrollment, for example, decreased by one percent in 1994, the first reduction since 1986, and diploma program enrollment continued to decline. In contrast, enrollment in B.S.N. programs increased, with a 1.8 percent increase in generic students, who have no previous nursing experience, and a 10.7 percent increase in R.N.'s pursuing the bachelor's degree. The Pew Health Professions Commission on the supply and distribution of U.S. health care providers counsels nursing to reduce associate and diploma degree programs because of their "inadequacy in addressing the potential opportunity and enormous demands that will be placed on nursing in the future," and to increase its preparation at the baccalaureate and graduate levels, which "will permit the nursing profession to develop the information background and experience base to operate more independently, work in community settings, [and] more effectively manage the health of patients."[45] It is projected that by 2000 only half as many B.S.N. and higher degree graduates as needed will be available, which translates to a deficit of 700,000 such personnel and a surplus of more than 200,000 A.D.N.'s.[46]

The past several decades have witnessed a continuing debate on the issue of entry into nursing practice, namely, how best to provide the public with nurses who deliver safe, cost-effective, therapeutic, quality care, which has been a source of friction within the profession. The American Nurses Association, the National Commission on Nursing, and the American Association of Colleges of Nursing advocate for requiring the B.S.N. as minimum educational preparation. The U.S. Army Nurse Corps, for example, made that degree an entry requirement in 1979, when it decided that all officers must have earned it, and more than 98 percent of its members now have the B.S.N.[47] Some authors echo this position, believing that nurses with this degree demonstrate more skills in psychosocial and familial needs of patients, leadership, teaching, and critical thinking and clinical decision making than nurses with associate degrees. B.S.N.'s are also better prepared to function autonomously. The attributes associated with these graduates are essential for future nursing practice, as the emerging health care system will require nurses with a broad educational base to (1) function independently, (2) demonstrate leadership skills, (3) be research-oriented and manage informational databases in decision making, (4) possess population-based perspectives in health care, and (5) be accountable for their professional practice.[48]

Scale asserts that of three basic models, only B.S.N. programs offer the degree of comprehensiveness, holistic understanding of the human body, mind, and spirit, and depth and breadth of knowledge required for the future. Scale argues that the National Council of Licensure Examination weighs heavily on the competency at associate degree level: "Registered nurses, the largest caregiver group in healthcare, [have] one of the lowest educational levels of all healthcare workers."[49] In the same tone, Dillon notes that the A.D.N.- prepared nurse does not "fit" the description of the nurses needed for the twenty-first century.[50] These anecdotal arguments lack sufficient data and systematic evaluations.

What is the downside of requiring the B.S.N. as entry to practice in professional nursing? By its imposition nursing faces several dilemmas. First, a majority of the current workforce, although not so prepared, has made significant contributions to the health of the general public and to the nursing profession. Those nurses would likely feel discounted, threatened, and devalued by such a proposal. Second, minorities, low-income, and older nontraditional students might be discouraged by this development, since they tend to concentrate in shorter-length and lower-cost associate degree programs, 90 percent of which are funded through federal, state, and local taxes, while only 50 percent of B.S. education is subsidized by public support.[51] With minorities already underrepresented, the gap between demand and supply of their services may widen. State-level organizations in Massachusetts support all three types of programs.

In 1992, the Special Commission . . . Relative to the Practice of Nursing, in consideration of public support, geographic accessibility, and financial affordability, issued a statement supporting "educational programs to prepare nurses at all levels — from entry through doctoral study."[52] According to the commission, these multiple levels prepare nurses for specific practice arenas with varied areas of expertise and responsibility, which may benefit a diversified health care market. The commission was established in the aftermath of two legislative proposals by the Massachusetts Nurses Association (MNA), namely, to require the baccalaureate degree for entry to professional nursing practice and to establish two levels of nursing practice — professional (B.S.N.) and technical (A.D.N. and diploma). Nursing schools and agencies that opposed this effort dominated the testimony and political process, and the MNA's effort ended with the legislature's taking no action. However, it was recommended that the Special Commission study the matter.

Its labyrinthine professional definitions, educational pathways, and practice patterns tend to confuse the general public and create friction within the nursing profession.[53] The lack of clearly defined competencies and differentiations in practice according to educational preparation can lead to ineffective and unfair use of the nursing workforce. Situations are created in which nurses with various levels of preparation perform the same duties or nurses with one level of preparation do everything, or practitioners with different levels of preparation perform different, interrelated tasks.[54] To create an effective workforce, nursing must demarcate its practice.

Differentiated Practice

The rationale for differentiated nursing practice has two fronts: professional and public. Professionally, it leads to increased satisfaction for nurses, provides clear career expectations for graduates seeking professional advancement, utilizes nursing resources efficiently, and compensates nurses fairly on the basis of their expertise, contribution, and productivity.[55] On the public front, consumers are entitled to learn the level of competency, educational preparation, and expertise of the providers. The old saying "A nurse is a nurse is a nurse" confuses the public and relegates all nurses to the lowest common denominator.

Diversified nursing practice, an approach to assuring quality care through the best utilization of nursing resources,[56] allows nurses to fill roles for which they were educated.[57] The purpose of varied practice is to structure nurses' functions according to education, experience, and competency.[58] Competency connotes a standard of skills and knowledge that is the basis for professional accountability. As health care moves into a

wider variety of settings, attention to the diversity in capability to occupy different niches in nursing becomes important. Each level of differentiation brings various skills and abilities to providing care for consumers. Differentiated nursing practice can be a powerful force in meeting the heterogeneity and complexity of health care requirements.[59]

In a collaborative effort of representatives of the American Nurses Association, Assembly of Hospital Schools of Nursing, National Association for Practical Nursing Education and Service, National Commission on Nursing Implementation Project, National Federation of Licensed Practical Nurses, National Federation of Speciality Nursing Organizations, and National Organization for Advancement of Associate Degree Nursing, the National League for Nursing developed a statement in support of differentiated nursing practice.[60] This multinursing organizations' paper was a response to a social cry for health providers to exhibit effective practice and cost-consciousness.

Several projects have been launched to differentiate nursing practice since then. For example, the Midwest Alliance in Nursing's project, funded by the W. K. Kellogg Foundation, distinguished between the competencies of A.D.N.'s and B.S.N.'s in three major components: provision of care, communication, and management.[61] The project proposed that B.S.N.'s assume more assessment, monitoring, and evaluation roles than A.D.N's, and furthermore, that B.S.N.'s use foresight to negotiate long-term goals with clients in developing a holistic plan of care, while A.D.N.'s negotiate with clients to establish short-term goals consistent with the overall plan. Models for differentiated practice, which delineate role, function, and complexity with respect to clinical competencies and decision making, have also been developed in hospitals.[62] Diverse competencies for B.S.N.'s and A.D.N.'s have been formulated by the New Jersey State Nursing Association and the Western Interstate Commission for Higher Education.[63] All these models include delineating roles among nursing personnel and identifying requisite capabilities for attending to recipients within a specific practice environment.

Massachusetts has seen the implementation of several regional and local initiatives to develop education and practice consortia that include differentiated practice, but only pockets of information about these efforts have been documented.[64] Such attempts have been seriously undercut by a lack of comprehensive data to describe the Massachusetts nursing workforce and by the absence of a mechanism to determine current and future needs for nursing supply, distribution, and practice in the region. Until such data are available, the state is hamstrung in its efforts to develop a rational statewide plan to implement differentiation..

In 1995, the Massachusetts Board of Registration in Nursing, in collaboration with the state nursing community, submitted a grant proposal to study the region's workforce. This proposal aimed at establishment of a statewide system for workforce planning and an ongoing means of collecting, analyzing, and disseminating the data. Massachusetts was a semifinalist, and Boston's Northeastern University School of Nursing received the $200,000 grant for this project from the Robert Wood Johnson Foundation. Its results will provide valuable information for identifying and analyzing the nursing workforce and lay the groundwork for the development of a differentiated practice model. Information furnished by a comprehensive and aggregate database is essential to ensuring the adequate supply and appropriate use of nurses, proportionate geographic distribution of nurses and educational programs, minority representation, relevant curricula, and adequate numbers of faculty.

The basic premise of differentiated practice not only supports efficiency, it also clarifies paths for career mobility. As we advocate for differentiated practice to best utilize

R.N.'s from varying entry levels, we champion educational mobility that expedites their mastery of new knowledge and responsibilities as they engage in a new health care market.

Educational Mobility

Health care is transforming the practice area from an episode-based hospital setting to an integrated and community-based environment. This shift demands nurses competent in comprehensive assessment and risk determination, critical thinking and shared decision making, crisis resolution, cost-effectiveness, research, ongoing cross-site management, and cultural competency. Nurses are also called upon to develop and use information systems and collaborate across disciplines. Such a challenge necessitates educational mobility to enhance the marketability of R.N.'s in the changing health care climate.

Educational mobility refers to a process through which two or more distinct programs cooperate to accommodate the learning needs and career goals of students with minimum repetition of learning experiences.[65] Articulation is one means of educational mobility by which a multilevel nursing curriculum design is organized and taught in a way that promotes transferability of credits from one level to the next. Educational mobility should allow an individual to climb a career ladder that with each rung leads smoothly to a higher academic degree or credential, for instance, associate to baccalaureate.

The National League for Nursing and the American Association of Colleges of Nursing support educational mobility. In fact, their social policy statement calls for "developing an academically, fiscally, and socially responsible system of nursing education that will assure the educational mobility of individuals who elect to pursue additional academic preparation in nursing . . . and accommodate an increasingly heterogeneous student population."[66] Educational mobility will also help to satisfy the "continuing high demand for nurses with baccalaureate and higher degrees in nursing, and encourage programs to advance the educational levels" of nursing.[67]

There are wide variations in the degree to which nursing programs are distinct from one another.[68] Articulation models range from case-by-case negotiations between individual programs[69] to areawide projects such as southwest Florida's, which include licensed practical, associate degree, and baccalaureate degree.[70] Other noteworthy statewide articulation plans in higher education exist in Maryland,[71] Colorado,[72] Connecticut,[73] and Georgia.[74] These exemplars start by identifying the common core knowledge and distinct differences of each nursing track. They then restructure educational levels, which allows transfer from lower-division to higher-division schools in the same field as long as mutually agreed-upon standards or criteria are met.

> If the nursing education system was perfectly articulated, there would be no need to validate previous knowledge or even to have an open curriculum. The LPN curriculum would constitute the first year of the associate degree curriculum, the associate degree curriculum would constitute the first two years of the B.S.N. curriculum, the B.S.N. curriculum would constitute the essential prerequisites for the MSN curriculum and the MSN curriculum would be an integrated component of the doctoral nursing program.[75]

The Massachusetts Board of Registration in Nursing supports and promotes efficient educational mobility for nurses.[76] Some of its nursing schools have made one-to-one agreements between individual programs for educational articulation and some have a more comprehensive agreement. For example, the University of Massachusetts Dartmouth, in collaboration with regional consortia of associate degree, diploma, and licensed practical nursing programs, has developed an area articulation plan that enables nurses to pursue a continuum of education throughout their professional careers. A uniform statewide articulation plan that would standardize the trajectory of nurses who need and desire to continue their education has not yet been developed, for its creation requires a political process. Consortia from both private and public sectors have to be established to identify, discuss, debate, analyze, negotiate, compromise, and finally agree on political solutions to a statewide plan. In this process, the nurse educators' willingness to explore the commonalities of educational programs is a prerequisite for the model development.[77] Similarly, R.N.'s' previous learning and professional experience must be valued and recognized. Policies regarding transfer of academic credits for graduates have to be developed. The awarding of transferred credits is most appropriately based on course content and learner outcomes in addition to number of courses and class year.[78]

Educational mobility is also enhanced through collaboration between education and service. Employers can facilitate mobility through creative scheduling options, tuition reimbursement, scholarship aid packages, and resource persons who can help employees sort through the various existing options, whether local programs, credible self-paced programs, or distance education with competency-based packages. A model of distance education overcomes geographic barriers for some students. Well-coordinated approaches assure mobility that will best serve individual students, educational institutions, the nursing profession, and the general public.

Furthermore, educational mobility in nursing helps to level the playing field for the socially, economically, and educationally disadvantaged. For years, urban health sectors have fulfilled a societal role by employing inner-city poor and others who have moved from entry-level jobs into careers in one of the professions. Some argue that the use of the health care sector is a vehicle to provide upward mobility to the lower classes, whose members view it as a major source of employment, but we disagree. Special efforts, public and private, are needed to aid promising individuals who began in entry-level positions to assume leadership roles through expanded educational pathways. Existing career ladder programs must be broadened to make upward mobility as flexible, feasible, and accessible as possible. Just how this might be done is beyond the scope of this study.

As the health sector is restructured and nurses in the workforce relocate to new environments, their practice and purpose will be redefined. This sector must address their training and retraining requirements and develop programs that prepare them for redeployment from practice in acute care to practice in home health, nursing homes, and managed care or allow them to remain in an acute-care setting but practice at the highest level of acuity and critical care. In order for nurses to be responsive to the changing health care environment, nursing must retool its workforce.

Retooling the Workforce

Nursing retooling is under way in several states, including Colorado, New York, South Dakota, Utah, and Washington. In these states, nurses associations have been active in helping to enact legislation for the establishment of redevelopment programs for R.N.'s who have been displaced by hospital restructuring. Mississippi joined their ranks in 1996 with the passage of Senate Bill 2269, the Office of Resource Development Act. The Mississippi model is unique in combining public and private funds in an effort to "confront the challenge of moving the nursing profession proactively toward a strong future by the planning and implementation of a program for workforce redevelopment."[79] Concurrent with the passage of the bill, Mississippi received approximately $200,000 from the Robert Wood Johnson Foundation's Partners in Caring Program. The state combined legislatively mandated seed moneys with private funding to establish the Office of Workforce Redevelopment. Its goals are (1) to establish a statewide plan to assist nursing educators and health care providers to meet the challenge of workplace changes through enhancement of nursing education and practice skills, and (2) to develop a statewide annual nursing workforce survey. Projected outcomes are (1) to develop a model to delineate a common core of nursing knowledge to assist students in articulation and mobility within the multilevel nursing educational system; (2) to develop and implement a state educational program directed toward nursing educators regarding health care delivery system changes and the impact these changes will have on curricula and on the retraining needs of nurses; (3) to develop and implement a systematic annual survey for nursing workforce needs and projections; (4) to establish a model for statewide career counseling for new graduates and nurses displaced owing to changes in the health care delivery system; and (5) to develop continuing education programs to enhance job mobility within the health care workforce.[80]

This model mirrors the work of a similar Northeastern University project, and it will be interesting to compare the two results. The Massachusetts health care system is already changing. In Mississippi, the full impact is still two to three years down the road. We suggest that the following areas, which deserve special emphasis because of their specific importance to nursing education and practice, be included in the retooling.

Caring for Older Adults

As indicated previously, the population is aging, particularly in Massachusetts. This trend demands geriatric, gerontological, and long-term-care nursing services, both in homes and in facilities. It is projected that roughly 260,000 geriatric nurses will be needed by the year 2000.[81] Yet not enough nurses have the education necessary to meet such a demand. According to the American Nurses Credentialing Center, a subsidiary of the American Nurses Association, of the 2.2 million U.S. R.N.'s, only 16,852, approximately 0.08 percent, are certified in gerontology. Most new graduates indicated a clear preference for working in an acute-care hospital over working in long-term-care facilities.[82] Factors cited for spurning the latter include the disincentives of lower pay, heavier workload, lack of opportunity for professional advancement, and negative media images. Efforts must be made to recruit new graduates to enter gerontological nursing and to counsel nursing assistants and aides, whose patients comprise the majority of personnel in long-term-care facilities, to advance their careers through educational mobility. Again, a statewide articulation plan would facilitate it.

The shortage of gerontological nurses and lack of interest in working in gerontology can be partially explained by the lack of a gerontological curriculum in nursing education. Many undergraduate programs have no separate courses in gerontological nursing, and few faculties are prepared in this speciality. Furthermore, the National Council of State Board Examinations for R.N.'s gives insufficient attention to developing test questions in geriatric and gerontological nursing and the long-term-care needs of older adults. We recommend that all basic programs incorporate these subjects in their educational curricula, including theories of aging, the aging process, age-related changes, the scope and practice of gerontological nurses, and gerontological research. Both curriculum and clinical experience in gerontology should be multidisciplinary in perspective and structured to engage students in the dynamic interplay that occurs between older adults, their families, the environment, and the sociopolitical structure that affects and is affected by the phenomena of aging.

Services required by older adults with chronic conditions encompass preventive, supportive, intermittent, and long-term care, many of which can be provided in the community or in the home. Nursing management can be a viable, cost-effective alternative to providing traditional, institution-based long-term and chronic care services to this population.[83] Nursing's holistic perspective of human beings and its background in the biological and behavioral sciences offer a strong basis for addressing the full needs of elderly clients. Care management skills are those associated with providing continuing cost-effective care, understanding the total trajectory of disease processes, using a database for decision making and care planning, and coordinating and monitoring the quality of services. The concept of care management for older adults must be integrated into gerontological practice and education. At the federal level, funding for geronto-logical traineeships is much needed. Such support provides educational opportunities and incentives for both faculty and students.

Equally important, regulatory changes are necessary to address service reimbursements for gerontological nurse practitioners. The American Nurses Association reports that care provided by nurse practitioners compared with care provided by physicians is equivalent in terms of satisfaction with health care provided, compliance with treatment recommendation, and knowledge of health status and treatment regimens.[84] Patients cared for by nurse practitioners required slightly fewer hospitalizations and the cost per visit was 39 percent lower than that for a visit to a physician. Despite the viability of a care management model, a major difficulty is funding, since many of advanced practice nurses' services are not covered under current reimbursement mechanisms. Although data related to the effectiveness of nursing care management in community-based settings are available, direct third-party reimbursement for nursing services has not been secured.

Managing Information

Transformation from an industrial age to an information age brings new meaning to nursing education and practice. Distance education and digital and interactive multimedia are becoming viable alternatives to traditional classroom teaching. In the practice arena, dramatic developments in health care and information technology are affecting people's lives. Electronic synthesis of patients' histories and research findings

are employed, for instance, to support and provide diagnostic decisions and treatment recommendations. Health care decisions will be increasingly data-driven, and skills in managing and utilizing information databases will be integrated with nurses' clinical decision making. Nurses must therefore be prepared to collect, analyze, and utilize data through information technology. In the future, an increasingly informed and assertive public will use information technology for guidance and support concerning their health and become more involved in making decisions about their care. Accordingly, teaching health skills through information technology will be critical to meeting the needs of informed consumers.

Moreover, there is growing use of and interest in telecommunication technologies, called telehealth, in delivering health care services. The mechanisms of telehealth include telephones, computers, interactive video, and teleconferencing. Telecommunications have the potential to expand access to care across state and country boundaries, which has implications for a state-based regulatory system whose primary responsibility is the protection of the public. The issue of cross-state practice through the use of telehealth by nurses can be difficult because laws and regulations governing nursing practice differ from one state to another. It is often not clear which state laws will apply to which nurses in furnishing telehealth services across states. The question of how such a regulatory system can effectively adapt to the increased utilization of telecommunications in health care while safeguarding the safety and welfare of the citizens has yet to be answered. The American Nurses Association, in response to the use of emerging telecommunication technologies within health care, suggests developing policy, standards, regulations, safeguards, and monitoring mechanisms to protect the general public.[85]

Nursing Practice and Research in the Community

Nurses are called on to develop community-based practice and research skills because greater numbers of acutely ill patients are being discharged early from hospitals and cared for in the home and through community agencies. Nurses have a key role in managing patient care in community settings. They coordinate care and integrate its delivery whether the goal is to improve clinical outcomes, provide less expensive care, or improve patient satisfaction. Key competencies for community-based practice include assessment, covering that of individuals and their families, groups, and populations, understanding the diverse nature of communities, and coordination with other disciplines. Community treatment in the managed care model particularly emphasizes consumer education, self-care, and preventive services. Nurses must learn to empower and motivate those they serve to participate in their own care. These two qualities are critical variables in providing quality care and enhancing its outcomes.[86] Another important quality for nurses in the emerging paradigm is the development of political assertiveness to influence structural variables affecting consumers' health. Just as they advocate for clients, nurses must become more powerful in advocacy on their own behalf.

A changing health care delivery system also introduces a new purview for nursing research. Population-based research and result measures are two areas in which nursing can make a significant contribution. Such research strives to understand the spectrum of health within populations that encompass diverse levels of human conditions. Because

people are collections of individuals, nurses must study the interaction between and among those whose health experiences are shaped by macrostructures of history, relationships, politics, economics, and environments and recognize the fundamental tenets of multiculturalism and working with diversified communities.[87]

Restructuring and redesigning the health care delivery system has dramatically altered the care environment. Determining the effectiveness of the emerging system calls for conclusion studies, research that evaluates the quality and effectiveness of services, structures, and organizations. Until fairly recently, national studies of health care have focused on morbidity, disability, and mortality. Such measures can be problematic for nurses, whose focus is not on disease but on human responses to existing or potential health problems, and ultimately on improving clients'quality of life.[88] Result measures for nursing practice and education have to reflect quality of care and cost-effectiveness. In response to the need for broader outcome measurement, the Agency for Health Care Policy and Research (AHCPR) was established through enactment of the Omnibus Budget Reconciliation. The AHCPR's research program examines the availability, quality, and costs of health care and investigates ways to improve it.[89] AHCPR funding facilitates health professions, enabling nurses to conduct research on patient effects.

The clear articulation of nursing interventions is necessary to provide indexes for developing nursing final measures. Although nursing has been slow to clarify to the public exactly what nurses do and whether their efforts make a difference in patient outcome, progress has been made. For example, the Nursing Minimum Data Set was developed in 1987 to establish uniform standards for collecting data in nursing services,[90] and the University of Iowa Intervention Project developed comprehensive standardized language for nursing interventions.[91] Such research provides policymakers with data from which to make informed decisions in relation to access to care, allocation of resources, cost benefit, and quality of care. Still, more efforts are required to make available on automated systems national data for nurses' actions, functions, interventions, and services that promote clients' quality of life.

Diversify the Nursing Profession

Demographic diversification within the American population has important implications for nurses. During the first half of the 1990s, the U.S. minority population grew by 14 percent compared with a 3 percent growth in the white population. Between 1990 and 1995, the Asian population grew 23 percent, the Hispanic population 20 percent, and the African-American population 8 percent. Hispanics are projected to outnumber African-Americans within the next fifteen years.[92] By 2050, about 50 percent of the population will be nonwhite.[93]

Policymakers and health care organizations are challenged to develop culturally and ethnically appropriate delivery systems for which to foster a disparate workforce. Does the current nursing profession represent the diversity of the American population at large? The answer is no, the nursing workforce is far less diverse than the nation's population. Only 9 percent of all R.N.'s come from racial/ethnic backgrounds: African-Americans 4 percent; Asian/Pacific Islanders 3.4 percent; Hispanics 1.4 percent; and Native Americans 0.4 percent; men account for about 4.3 percent.[94] New England, with only 3 percent of the total, has the lowest number of ethnic minority nurses in the nation.[95]

Nursing school faculty is less diverse than staff in other disciplines nationwide, minorities comprising 8.8 percent of all nursing faculties versus 10 percent for faculties within all other disciplines.[96] In the north Atlantic region, 92.9 percent of nursing faculty are Caucasians, with only 7.1 percent minority.[97] Between 1980 and 1990, the number of black R.N.'s rose by only 0.3 percent, and from 1989 to 1992, the percentage of black students enrolled in R.N. programs fell from 10.3 percent to 8.6 percent. Simultaneously, among all other college students the percentage of blacks climbed from 8.7 to 9.3 percent.[98] Furthermore, the health-sector labor force is shaped like a pyramid, with blacks and other minorities underrepresented in advanced practice at the top, and overrepresented in nurse's aides and assistants at the bottom.

Minority underrepresentation in health professions indicates a failure to recognize and fully develop the human resources in our assorted population.[99] As indicated previously, minority populations continue to suffer health disparities in comparison with whites. As health professionals, nurses clearly see the effects of inequality on many people of color: their inability to access and pay for health services, lack of equitable, culturally appropriate health care, poor outcomes of care, and exclusion from the health-planning and decision-making processes that affect their care. Inequality and inaccessibility lead to disparities evidenced by much higher rates of morbidity and mortality in minorities than in the population at large.

Some discrepancies might well be decreased if the largest number of health care providers and nurses equally reflected America's changing demographics. Minority nurses have helped to reduce many of the barriers to health care that ethnic minority groups encounter, encouraged high-risk groups to seek care, and played a vital role in the lives of clients of color.[100] Minority nurses and nursing students are more willing to work in geriatric settings, as indicated by a 1981 research project that surveyed 3,942 student nurses in forty nursing education programs and 5,300 R.N.'s concerning their willingness to work in that field.[101] The study revealed that proportionately more minorities, about 60 percent, both nursing students and R.N.'s, intend to or already pursue care of the elderly than nonminority personnel, 40 percent. The nursing profession can no longer afford to prepare nurses to care for patients from the standpoint of only one cultural or racial group — white, middle-class male — and effective care can no longer come in a single form to fit the needs of a heterogeneous society. The American Nurses Association indicates that inattention to cultural diversity is no longer merely morally negligent, it is also economically impractical because a culturally varied cadre of nurses is crucial for providing cost-effective, culturally competent care to an increasingly disparate patient population.[102] Nursing must intensify its efforts to reflect the same dissimilarity in its workforce.

As nursing calls for increasing ethnic variety within its ranks, so must it integrate cultural competency into its educational experience. Multiculturalism has to be embraced within the core of the nursing curriculum. Existing ideologies of domination and oppression must be examined critically to develop vital consciousness among nurse educators, administrators, and students. The realities of racism, sexism, and classism must be understood to appreciate how discrimination continues to manifest itself in the health care system and in society.[103] Culturally sensitive care includes understanding oppressed group behaviors and recognizing that clients from many cultures may mistrust and be intimidated by a historically unfriendly system. To adopt diversity in the

educational environment it is most important that we listen as ethnic minority students express their concerns, ideas, issues, and suggestions and appreciate that their rich culture and experience are necessary to augmenting learning.

Equally as important are the recruitment and retention of minority nursing students. Achievement of this end requires major long-term strategies, since increasing ethnic representations cannot be accomplished simply by implementing standard marketing or tutoring programs.[104] The mission of the Boston Area Health Education Center (BAHEC), formed in 1978, is to alleviate labor shortages in medically underserved areas of the city. It is affiliated with the Department of Health and Hospitals, Boston University School of Medicine, and a network of neighborhood health centers, and its programs are supported in part by the University of Massachusetts Medical Center/ Statewide Area Health Education Center, the Boston Private Industry Council's Action for Boston Community Development, the National Institutes of Health, the Department of Health and Human Services, Division of Disadvantaged Assistance, the Department of Health and Hospitals of the City of Boston, Inc., and a collaboration of participating health career/educational programs. BAHEC currently offers programs in three areas — health education, youth programs, and adult training — designed to make opportunities in health available to minority populations, to improve the quality of health care in Boston's inner-city neighborhoods, and to recruit minority and other underserved populations for health careers.[105]

Strategies for career development have to be addressed as early as seventh grade. An early start helps minority students meet admission standards and process educational content and skills necessary to success in nursing programs. High schools should plan special recruitment programs to introduce minorities to the nursing profession. Counseling services may also be important for some minority students who are enrolled in predominately white schools, for they may experience a "cultural clash" in the white milieu.[106] Some people may consider minority students "not smart enough" and their cultural and language differences deficits rather than variations. Many nursing faculties must analyze their perspectives critically. Public funding is also necessary to support academically qualified but financially disadvantaged students. Educational mobility and career ladders are crucial mechanisms for minorities entering nursing at less than the baccalaureate level.

Affirmative action policy is necessary to the achievement of diversity in a nursing workforce that can meet the health care needs of the nation effectively. The elimination of affirmative action at a time when society is becoming more multifaceted not only threatens to turn back the clock in the strides made by the civil rights movement, but may also complicate and worsen the health disparity between whites and minorities and translate into underrepresentation of ethnic minorities in nursing.[107] Support for affirmative action springs from two major concerns, the first of which is to assure that individuals who achieve their full potential and contribute to the well-being of society are properly recognized. The second is the nation, whose economic growth and social cohesion depend on its paying attention to disenfranchised and marginalized individuals and groups.

When ethnic minority clients seek health services, they bring along their cultural beliefs, values, and health practices and expect the providers to be considerate of their culture and sensitive to their needs.[108] Our diversifying population creates a mandate for

nurses to provide cultural-specific health care. It is well documented that ethnic group nurses are at least twice as likely as their white counterparts to practice nursing within a culturally mixed area.[109] An ineffective monocultural approach to nursing will be even less effective in the future.[110] These, too, are reasons for retaining affirmative action!

Access to Nursing Services

There is ample evidence that nurses play a vital role in providing quality and cost-effective care to the general public. Nurses who teach patients in nursing homes reduce hospitalization rates among the elderly.[111] Nurses deliver needed services through intensive home visits to pregnant women, mothers, and infants, and help them to connect with other health and human services.[112] Clinical nurse specialists follow up on very-low-birth-weight infants who are discharged early and keep them well at home, saving $18,560 per infant in hospital fees.[113] Nurses promote healthy groups through neighborhood and community health nursing to improve consumers' access to care.[114] A nursing community service project helps young victims of domestic violence.[115] Nurses reach out to underserved, poor, marginalized, and high-risk populations in conducting health screening and teaching health promotion and link them to community health services. A 1996 survey by the Peter D. Hart Association reveals that Americans are receptive to R.N.'s' performing more basic health care services and providing home care to the elderly. Nurse practitioners and clinical nurse specialists have been found to lower cost and improve access to primary care for the poor in urban and rural settings. Nursing serves a pivotal role in helping and empowering consumers to take charge of their health. "The nursing profession is critical to a smooth transition from an episode-based and hospital-centered delivery system to an integrated continuum of care model."[116]

The present system of insurance coverage, however, serves as a strong disincentive to providing services in the home and other non-acute-care facilities in spite of the emerging health care model.[117] Payment policies and market forces continue to direct community and home care agencies to focus narrowly on the episodic care of acutely ill individuals. Nursing has long been concerned about the methods of payment for nursing services in institutions. Historically, nursing service costs in hospitals have often been and are lumped into the general category of operating costs under broad categories such as room and board. Charges for professional nursing care to patients should be removed from the daily room charge and billed separately as professional services. The flaw of a business-first and patient-care-second insurance system results in significant numbers of hospitals costing out nursing care. Nursing accounts for only about 20 percent of an average bill despite the fact that professionals spend twenty-four hours in around-the-clock care at patient bedsides. Money must be placed where the care is.

Reform is needed at the national level, particularly in nurse reimbursement policies. Data are extremely critical to assessing and analyzing the nursing labor force and the cost/service ratio and to interpreting nurses' roles in a wide range of care across a health spectrum such as prevention, geriatrics, and education. It is important for hospitals to have precise information about the costs and utilization of nursing service personnel in order to make the most appropriate and cost-effective decisions about assignments and to determine to what extent nursing care units are revenue or cost centers.

Federal policy should be reformed to allow for broad inclusion of clinical nurse specialist and nurse practitioners as Medicare and Medicaid providers. Widespread use of nurses as primary care providers in a variety of health care delivery settings would

realize substantial savings to the American public while increasing admissions of underserved populations,[118] if the nation's goal is indeed healthy people by 2000.[119] Nurses as cost-effective providers have more than a decade's data supporting the theory that nurses could replace relatively expensive physicians without impairing the quality of care.[120]

A changing heath care environment is dynamic, evolving, and challenging. As the nation explores reform, a window of opportunity for nursing opens. The profession, however, faces the challenge of determining the effectiveness of its workforce within a rapidly changing system. A new day calls for a new way. Nursing must (1) carve out its niche in the fundamentally changing arrangement; (2) become partners in care with an increasingly graying and browning consumer population; (3) utilize new biotechnical and information technology in managing care; (4) provide consumer health care through community/population-based services; and (5) engage in primary care with emphasis on health promotion and disease prevention. To utilize the nursing workforce effectively while preparing students for the next millennium, differentiated practice, educational mobility, and workforce retooling is imperative. Analysis of the nursing workforce must acknowledge continuing contributions of practicing nurses. Equally important, nursing must pay more than lip service to increasing ethnic diversity within the profession. The profession must also move beyond the division and ferment within its ranks, which are no longer tenable and in the long run will not add to the interest and purpose of the health care system and the people it serves. Massachusetts nursing must position itself proactively to ride the wave of change rather than crash into it. Finally, nurses must become much more astute and active in influencing public policy. Participation in policy development and political dialogue is vital not only for nursing, but most important, for the health and well-being of the general public. Nursing has responded well to change in the past. It will once again meet the challenge of this new day.

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Job Mobility of Entry-level Workers

Black and Latina Women in Hospital Corridors

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Based on data from interviews with fifteen black and fifteen Latina women in entry-level jobs, this article discusses job access strategies, patterns of job mobility, and barriers to upward job mobility for low-income minority women in the hospital industry. Concentrated in the lowest wage levels and job tiers, they are quite diverse in subgroup composition, in age, and in training requirements. The research confirms that deficiencies in schooling and skills remain the major obstacles minority women confront when they apply for hospital jobs and restrict their opportunities once they are within the hospital labor market. Efforts to provide training and schooling opportunities have to address the constraints imposed on the women by work, family responsibilities, and modest income. The varied training requirements of women placed in entry-level tiers dispel the notion that they all have the same skill and aptitude levels. They ask that hospital employers and community-based training organizations develop better skill assessment instruments to improve the job-placement process so that potential employers cease equating absence of credentials or linguistic accents with low skills and low intelligence. The author analyzes the urgency to articulate services in a competitive adult and higher education environment and the pressing need of minority women to locate alternative mechanisms of demonstrating competence and securing school credentials in the United States. The women speak eloquently about the racism they encounter in the hospital workplace and of their need to identify means of support that enable them to attain the transfers, promotions, and recommendations they require to succeed inside the hospital labor market.

To understand poverty and inequality, one must understand how workers get, or fail to get, access to jobs with good wages and benefits. This is especially true for women who are overrepresented among the poor and for whom the greatest wage inequality results from their segregation into pink-collar occupational ghettos. In an increasingly polarized labor market, with midlevel jobs disappearing, female claims to

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quality jobs, wages, and benefits are critical to their economic well-being and that of their families. Positions in the health service industry provide an opportunity to examine the potential for women's economic mobility into quality jobs. In Massachusetts, for example, more than half the health and hospital jobs available are concentrated in the Boston area.[1] Though the industry includes hospitals, clinics, and other health facilities, hospitals remain the major employer, accounting for 70 percent or more of all employment within the health field. So large has Boston hospital employment become that it represents 14 percent of the city's aggregate payroll.[2] It is important, therefore, to identify how low-income women connect to hospital employment opportunities and to determine how they fare once inside that internal job market.

At the time of this research, Tier 3 skilled technician jobs were experiencing personnel shortages while unskilled and semiskilled Tier 1 and Tier 2 workers were in need of economic mobility. Tier 1 workers are employed in kitchen and food services, housekeeping, maintenance, and a variety of nurse's aide, orderly, and patient transportation. Tier 1 may also involve manual labor, which can be physically demanding. Tier 2 workers are employed in entry-level clerical positions, booking appointments, registering and billing patients, and entering data into medical records. Some Tier 2 workers draw blood, sterilize and prepare operating room tools, and produce graphs or computer reports for lab tests because training for these tasks can range from a few hours to a few weeks. This pool of Tier 1 and Tier 2 employees is where minority workers are concentrated and represents the group from which recruitment into Tier 3 skilled technician jobs is possible. In Boston, 80 percent of the residents who work in the health and hospital industry are employed in the lower tiers.[3]

Research Questions and Study Design

I used information from interviews with fifteen black and fifteen Latina women, in Tier 1 and Tier 2 positions in Boston area hospitals, to gather information on job access strategies, patterns of job mobility, and barriers to mobility. Each of the interviews was divided evenly between Tier 1 and Tier 2 positions. The black women include African-Americans and Jamaican and Trinidadian immigrants. The Latinas, similarly, include U.S.- born and island-born Puerto Ricans as well as women from the Dominican Republic and from South America. They are U.S. citizens from birth, so Puerto Ricans are not classified as immigrants, but the characteristics of the women with substantial island experience are consistent with those of new immigrant status.

While grouping the women into the broader black and Latina categories blurs important distinctions between them, I was obliged to do so because a small sample is required for qualitative interviews. Even for a small group, I experienced difficulty in identifying women to interview and "snowball sampling" techniques proved most effective in generating referrals. Most employer and union records identified women only as black or Latina, so that even if I had wanted to generate samples by distinct black and Latina subgroups, this would have been impossible with reliance on institutional data. I placed women in groups consistent with the identity they themselves reported so that a Spanish-speaking immigrant and black woman would choose the group she identified with. The way diversity between black and Latina women manifests itself and diversity within their own subgroups affects their labor-market experience surfaces in the analyses that follow.

I limited the sample to thirty to achieve depth within the constraints of time,

availability of sample, and acceptable numbers for cohort comparison. In fact, most qualitative interviews of women I consulted numbered twenty-five or fewer. As specific hypotheses are not tested in this research design, there is no need to attain a cohort size that supports the type of statistical analyses usually run in quantitative models. Other studies have documented labor-market segmentation well, so there was no need to further prove the racial or gender divide in the workplace. Rather, what was necessary was a microanalysis of the practices and interactions that reproduced this segmentation. The qualitative semistructured interview was the best means of securing these data. Qualitative interviews allowed me not to prove a labor market segmentation, which the literature shows exists, but to document how it is achieved in practice through the personal beliefs, perceptions, and experiences of workers inside the hospital.

Hospital human resource personnel were reluctant to provide access to their workers. They felt vulnerable about exposing their organization to complaints from minority workers, so my requests for names was met by only one of them. In hospitals with an organized labor union, the local steward provided assistance. This strategy also proved problematic as the steward struggled to produce membership rosters from which we could draw names and to contact employees whom she might not know. For many of the women in organized settings, the approach to recruit them for my interview was their first union contact.

Alumni information from community-based training programs was equally discouraging in locating graduates. The younger minority women emerging from these training programs were economically vulnerable, which led to frequent moves and adjustments in work, child care, and family arrangements. Their addresses and telephone numbers, therefore, quickly became outdated. Women had to have been on the job for at least one year, a period long enough for them to have developed an opinion about the hospital culture and internal labor-market practices. The interviews, most of which took place in the homes of the women after working hours, were recorded in English or Spanish. Because some of the women felt intimidated, afraid that their concerns would get back to their employers, they were guaranteed anonymity. Many feared losing their jobs, for the industry was beginning its cycle of layoffs. To encourage their participation, the women were paid ten dollars.

I discuss data on three research questions explored. The first is the school and background characteristics of the women that are relevant to understanding their outcome in the job market. School information is also relevant to our understanding of training needs to facilitate future job mobility. The second identifies job networks successful in getting the women jobs, especially a first hospital job. The third describes their work experience with the hospitals' internal labor market, paying particular attention to barriers that prevent the women from achieving upward job mobility and to the racial culture and climate of the hospitals. Moving to positions of comparable pay and status in other departments is *horizontal job mobility,* while moving to positions of improved pay and status is *vertical job mobility.*

School Characteristics Affecting Employment

The information on school completion rates was collected to confirm whether failure to progress within the hospital tier structure is indeed the result of human-capital schooling deficiencies. In evaluating school completion rates, I found important differences between women schooled exclusively in the United States as compared with those who

attended school outside the U.S. mainland. While black and Latina women had early and unplanned pregnancies, which interrupted their schooling, blacks as a group were more likely to suffer that experience.

Marriage and Pregnancy

The major factor contributing to U.S.-born blacks' leaving high school early was unplanned teenage pregnancy. Thirty-three percent of the black women left school because of an early pregnancy.

Shirley, forty-nine years old, attended an all-black, coed school in Alabama; dropped out at seventeen.

> When I was growing up, I wanted to go into the army. . . . But before I could finish high school, I got pregnant, at the age of seventeen. . . . I guess I was watching television . . . and I just . . . I want to jump off parachutes and stuff like that and I didn't get a chance to do that. Well, I thought about lots of things. Nursing too. Oh, I guess because my grandfather passed during that time and I had to do a lot of things for him. You know, helping. Help my grandmother with things. But I got pregnant and so I couldn't finish anything.

Unwed pregnancy as a determinant of leaving school early was as true of black women older than thirty as it was of the younger generation, those under thirty. One of the younger black women assumed that blacks' unwed pregnancy was more acceptable because black single mothers were so prevalent in the news and media. "Times had changed," she reported. When she attempted to return to her Boston public high school after the pregnancy, teachers told her she was providing the wrong role model for her peers. Their comments led her to withdraw from school a second time. Black women went on to raise their children substantially alone. Husbands and partners didn't hang around or couldn't provide help, and the women assumed sole responsibility for the children, even when they remarried. All returned to school to complete a high school program, but it took many years before some of them were able to do so. Forty-seven percent of the black women were pregnant or married right out of high school compared with 29 percent of Latinas. Thirty-three percent of the black women went into the job market directly after leaving or completing high school compared with 7 percent of Latinas. The latter, who also married and were just as economically needy, were entering formal jobs at a significantly lower rate.

Among the Latinas, both high school dropouts were Puerto Rican, the group these fifteen women perceived to be the most privileged owing to their U.S. citizenship status and superior American schooling credentials. Both, young and educated substantially in U.S. schools, left school to get married, one because of an unplanned pregnancy, the other to escape the continuous back-and-forth migration between Puerto Rico and Boston forced on her by her mother.

Ivelisse Lily, twenty-two years old; Puerto Rican; Boston public schools; dropped out at sixteen.

> I decided in tenth grade I wanted to marry — I was sixteen years old. My mother moved us so often, I wanted control over my own life. I wasn't pregnant but I got married at sixteen anyway.

For this young woman, marriage was the ticket out of chaos and the multiple schools she

never got to really know or settle into.

Foreign Schooling

Twenty-seven percent of the blacks and 43 percent of the Latinas completed their schooling on time in systems outside the United States. Six Latinas completed a high school education on time, five graduating from Boston public schools. Despite completing high school in Boston, however, all the Latina women had substantial experience with schools in Puerto Rico, the Dominican Republic, and some other South American school system. This meant that they struggled to juggle bilingual and bicultural experiences and expectations throughout their stay in the Boston schools. It also meant that even in cases where Latinas held a U.S. high school diploma, it did not mean they were proficient in the English language or that the bulk of their schooling had occurred in the United States. Many of the foreign-schooled women later had to complete a U.S. high school diploma or general equivalency diploma (GED) program to confirm or document a basic level of literacy. Their foreign schooling certificates and diplomas were not formally recognized in the United States.

The requirements of foreign school systems varied, making problematic issues of transferability. Puerto Rican schools, for example, reflect the American school system in structure as well as in much of the curriculum content, except that they are taught in Spanish. Among Latinas, this was expressed as a preference for Spanish instruction in Puerto Rico, where there was assurance that credentials could be easily transferred to the United States. In countries other than Puerto Rico, a schooling certificate was issued to students on their completion of about nine years of education and subsequently passing a national examination. Ability to pursue studies after the ninth-grade school certificate was often contingent on receipt of a government scholarship based on the result of the national exam scores. The only other route to education beyond ninth grade was to belong to a family who could afford to purchase additional schooling at a private institution. As the foreign schooling credentials of many students were not accepted in the United States, this meant that 60 percent of the black women interviewed and 57 percent of the Latina women interviewed had not possessed a minimum document of twelfth-grade high school certification that was valid in the United States at the time of the interviews. Irrespective of individual aptitude and skill level, the absence of that credential locked them, as a group, into low-wage work.

Substantial foreign schooling held a number of consequences for black and Latina female workers. It meant that they lacked English-language proficiency, were often forced to repeat a grade level in the United States, had the legitimacy of their schooling and credentials questioned and were denied acceptability under U.S. standards, and were at a great disadvantage in a Massachusetts economy in which 67 percent of jobs require a minimum of two years of college. Blacks and Latinas with substantial U.S. schooling fared no better. Five of the nine black women who attended U.S. schools enrolled in general studies programs, because it was the only course offered at their high school. Three of the five black immigrant women were enrolled in general studies programs because that was the only course their foreign schools offered.

Black/Latina College Plan Differences

As is evident from their general studies enrollments, women had limited choices early in their lives. Latina women were more likely than blacks to report an early interest in jobs or careers that required professional training in a four-year higher education program.

This difference in attention to college appears to be the result of different class and foreign schooling opportunities available to Latinas and blacks in this particular sample. Twenty percent of the black women, for example, went on to college or a year of Vista service after high school while 64 percent of the Latinas continued their schooling in a college or a university. With Puerto Rican and Dominican women predominantly composing the Latina group, this higher education finding reflects the broad availability of such schooling for Puerto Ricans on the island, as well as the great use of the Puerto Rican higher education system by Dominican migrants to the island in search of credentials acceptable in the United States. Migration and divorce were the two most important variables affecting interruption of higher education. Black immigrant women had more limited higher education opportunities in their homeland. Despite their superior schooling and skills, Latina immigrants worked at the same job levels as their less schooled and skilled counterparts in Boston.

Despite the fact that 59 percent of the entire group did not possess an American high school diploma at the beginning of their first job, all later reentered schooling and completed their high school education. Where they could, they selected programs offering a regular high school diploma over a GED. Of the fifteen black women workers, six had completed high school or a GED in the year preceding the interviews.

Vanquished Dreams

The black and Latina women came from homes where few parents and siblings had completed high school and virtually no one attended college. Forty-eight percent of these women's mothers worked as full-time housewives, reflecting the historic absence of job opportunities for women in the external paid labor force. The remaining mothers supplemented their housework duties with work as domestics or, later, in factories during economically stressful periods for the family. All the women's fathers worked and were the primary breadwinners of the household. Their contemporary experience, as predominantly single-parent mothers, was therefore a radical departure from that of their own upbringing.

The women reported few role models who could help or mentor them during their growing-up years. The major expectation was that they would finish school before becoming pregnant or marrying. "Finish school" meant completing high school, a basic minimum standard set by the parents. When asked how their lives and choices were different today, most women believed they were better off economically than their mothers or parents. One woman remarked that times were different and one had to assume different jobs and roles. She was not sure that the quality of life had improved as a result of those changes. The setting may have changed and farming and sharecropping were no longer the norm, yet economic and power relationships for minorities and women had not improved as dramatically. She was still working a low-level job for low wages, even if it had a new title and she lived in an apartment.

Early pregnancy and marriage were the result of vanquished dreams. Coming from public, all-black schools with general programs and hand-me-down books and clothing, their post–high school plans centered on the jobs available to black women — nurse and nurse's aide, teacher, and beautician. The few who ventured beyond these jobs were influenced by television and the hope that joining the military would whisk them away to some exciting travel or other opportunity. Immigrant black women faced similar career limitations because of the substantially lower family income levels abroad and the reduced availability of public schooling. For Latina women, there was no South. The older

ones were immigrants from the Dominican Republic. The Puerto Rican women were younger, second generation, but their substantial U.S. schooling did not translate into economic gains for them in the job market.

Florence, forty-three years old, service technician, Jamaican immigrant:

> There are certain things [my parents] couldn't do. I took the test for high school [in Jamaica] and I didn't pass. Well, then you have to have certain amount of money to buy certain things, uniforms and badges and different things that you wear. So, at the time, my parents, they were poor. They could not afford to do all that for me so I really didn't have any plans at all at that time. I was just at home, you know. [Parents] really didn't send you out to work because we were in the country. There would be no place to go to work anyways. Well, some children leave home and they go in town after they get out of school. And then they work. But my mother didn't want for us. . . . Because, you know, those parents, they're so protective of their children. They didn't want us to go around at the early age [most completed schooling by fifteen years]. My father worked very hard for all of us. He pushed us. He loves to read. He always wanted us to have new not old books [and worked extra hours to make sure we got new books when we did go to school].

Ana, thirty-two years old; medical records clerk, Dominican immigrant:

> I wanted to be a psychologist. Later . . . all I wanted to do was *escapar del mapo* [escape from the mop]. I lost those dreams. Money [needs] forced me to begin domestic work at an early age. My mother divorced when I was nine years old and raised six children on the wages of a domestic worker. At nine years I went to Puerto Rico and attended public schools there. At seventeen years, I asked to come to the U.S. I finished high school here. I came to Boston to explore, *adventurar* [seek adventure]. In my senior [high school] year, my older sister was moving to Boston to join me. I was anxious to get my own apartment so we can move in together. I needed a job and money. College was a distant thought in my mind. Desired, but simply not possible.

The younger black and Latina women, under thirty, had profoundly different schooling experiences and career goals. They were products of a different era in television, of a post–civil rights period, of the women's movement. They were encouraged and pushed in school to tackle computer programs, science, and technical careers. Despite greater exposure to career paths, the young blacks and Latinas did not necessarily fare any better. One black woman wound up pregnant in eighth grade, replicating her mother's single-parent status. Another Latina also wound up pregnant in her senior year and never married the biological father.

Two young minority women were successful in pursuing computer programs at a community college level. That degree allowed them to secure the same entry-level clerical position the other minority women held. Both are worried about their ability to complete a four-year degree, something they have to do to attain the upgraded requirements of their job. One very bright black woman, in the final year of study for her four-year college degree, expressed dissatisfaction with Boston public school magnet programs. Her "high" grades led her to believe she was capable of performing academically, but the demands of her college program proved otherwise. She dropped the college program after two frustrating years, angry at herself and at the Boston schools. The quality of their public school education left them unprepared for the job market or the college work they undertook.

A Minority View of Work and Family Conflict

All these women viewed themselves as workers and wives. It was clear to them, early on, that marriage would not provide income security for low-income minority women. They fully expected to work outside the home, not perceiving it as interfering with the family, to work for most of their lives, and considered their wages essential to the survival of the family and the household. The hostile relationship often assumed in work and family literature did not exist for this group. They saw work as necessity not choice. The inability to project career paths was caused by the disruption of dreams as economic realities crashed in to pose real barriers to further training and schooling. The high school period proved critical for the women, who had the dreams but no concrete mechanisms for realizing them. As dreams were dashed, it was easy for them to surrender to the traditional expectations of motherhood with unplanned pregnancies, early marriages, and other compromises that steered them dramatically away from their plans. Marriage and family was an "acceptable" alternative sanctioned by family and society when women were unable to penetrate structural barriers of limited schooling and employment.

Job Mobility and Work Experiences in Hospital Corridors

In addition to formal schooling and human capital skills, other factors affect one's access to jobs and success and experience on the job. I collected work history data to evaluate whether the women experience vertical job mobility — an increase in pay and job rank — or horizontal job mobility — another job at the same wage and rank. The information on work history allows me to report on how the women connected to their first hospital jobs, how women experience race and ethnicity in their current hospital positions, and how internal hospital labor practices affect them. Internal labor market refers to employment opportunities within one company or firm and to the policies and practices that define access to job hierarchies within that firm.[4]

Job Search Strategies

When asked how they find work and what method is best for them in locating information about employment and transfer opportunities, the women identified newspaper ads and internal postings as their main and regular source of information. Despite this, when pressed for specific information about how they had secured their current position and who had helped them find earlier positions, it appears that most had been successful in locating jobs and transfers through other means. The most satisfactory job search strategies involved heavy reliance on publicly funded, community-based training program services, followed by the help of kin and friends. Sixty-three percent of the technician assistant employees got their first job in that category as a result of a training program placement. Several of the women started in technician assistant jobs in their first institution and subsequently moved to another one when their classmates recruited them. Moving to be with their fellow students afforded them a more comfortable working environment, with people they knew, even when they were unable to negotiate wage increases.

U.S.-born black women were more knowledgeable about the use of community-based programs, knew of more agencies they could tap for services, and were more likely to report using an agency for training and job placement assistance. Latina women were less knowledgeable about training agencies. When they used such an agency, it was usu-

ally the result of a referral from Aid to Families with Dependent Children (AFDC) or an immigrant service program.

Another reason for the unevenness of the job search and information networks of black and Latina women was that the latter simply had less experience looking for work. The black women were wiser about job searches because they had held more jobs and had been in the formal labor market longer than the Latina women. Only two of the fifteen blacks were in their first full-time job, referred to hereafter as first-time jobholders. Both were young and unmarried high school graduates from Boston. Among Latinas, five who had no prior work experience in the formal job market, not even part-time, were in their first full-time permanent job. Another four Latina first-time jobholders were housewives who migrated to Boston with their spouses. They entered the formal paid job market primarily by enrolling in short-term training programs and using the placement services or momentum of the program to locate employment. One Dominican woman, for example, located her first job as a clerk-typist during her five-month internship as a training program data entry clerk intern. The training program pushed her employer to locate full-time work for their trainee placements. Without that external shove, she believed she would not have been hired, as she had applied for work there previously with no success. Her training site supervisor helped her apply for a permanent position in the same hospital with a publicly funded community health program. Her first job, therefore, was in a grant-funded clerical position, where job security ended with the end of the grant.

Before their arrival in the United States, immigrants, especially the Latina women who comprised a larger proportion of them, had limited job search experience of a different nature. In migrating to this country, they had to learn new ways of interacting with institutions and people. As noncitizens, they were not always clear about their eligibility for training programs and services. The short training programs available at community-based organizations were insufficient for them to achieve job-market entry, particularly considering the diversity of their English-language deficiencies. One woman participated in a job-training program that did not lead to a job placement. She went home and raised her kids on AFDC for eleven years. When AFDC rules tightened, she returned to the same clerical job training in the same Latino organization. Again, no job placement resulted. She finally found a job on her own, after pleading with a Latino human resource employee who put her in housekeeping irrespective of her two clerical training program certificates. She remained there for several years before being able to move horizontally from housekeeping into entry-level clerical work.

Job Mobility in the Hospital Labor Market

It is important to note that while black and Latina women regularly review job postings, their ability to execute a transfer successfully has usually been prompted by personal intervention. It may have been by staff of a program or agency that trained them or by a relative or friend who spoke directly with the hiring supervisor on behalf of the woman. The only two jobs Ivelisse ever held were secured for her by her sister. In both cases, Ivelisse submitted applications for work that went unheeded, and she received calls for an interview only after her sister, already employed at the site, spoke directly with a supervisor on her behalf. This strategy may work well for white workers. Relying on insiders to obtain a job works less well for black and Latina women, who are represented in lower numbers in the workforce generally and are less likely to have supervisors or

peers in higher positions who can intervene on their behalf. They cannot turn to their traditional mentors, the staff at community-based organizations, because the role of their staff usually ends with job placement.

With respect to internal transfers, the women did not perceive supervisors as a source of support or information in helping them to locate jobs or transfers. Immediate supervisors were often viewed as insensitive, incompetent, and untrustworthy and viewed as favoring one employee over another. In limited cases where supervisors were cast in a more positive light, they were viewed as well meaning but powerless. Women reported routinely applying for jobs and being rejected for what they perceived as vague reasons. The information on the cause of their rejection would not help them prepare for a more effective future interview, since they did not know if they could trust the accuracy of what they were told. Blacks and Latinas alike reported that having a "mentor," the term used by black women, or a *padrino* (sponsor), the term used by Latinas, was more important in getting a job than one's qualifications. While jobs were posted, women knew of specific cases in which the position had already been committed to someone else, a process that left them feeling powerless. They very much wanted a mentor or padrino and often asked if I could help identify and locate one for them.

Ana, patient advocate:

> I applied three times for that position. I was the internal candidate . . . internal candidates are supposed to have preference. I later found out the new hires were friends of other workers.

Ines, data entry clerical:

> I worked in housekeeping because I spoke no English — that was all I could do. I took an [in-house] computer course while in housekeeping to get [a position in] medical records. I kept applying and was turned down several times. They always told me "seniority." I had no clerical experience. I ignored the prerequisites — *Me arriesque!* [I took a risk.] I learned everything in one week.

The Effects of Seniority on Job Mobility

The frequent movement of women between jobs and employers needs as much explanation as their inability to move out of a low-wage job after a long tenure. Job tenure or seniority, therefore, is an important variable that contributes to our understanding of job mobility. Most of the women had been with their employer for less than four years, so they would lose out on positions in which seniority is a criterion. Seventy-six percent of the women interviewed had been with their hospital employer four years or less. The majority had been with their current employer in their current position a little more than two years. Those who had the greatest seniority were a small number of U.S. black clerical workers whose upward job mobility had been constrained by their lack of schooling. They had no high school diploma, so they could not move elsewhere. It was this group that, after five to eighteen years of service in the same department of the same hospital, was most active in completing the requirements for a high school education over the year preceding the interviews. This finding among clerical workers is consistent with black female labor-force participation literature, which confirms that black women's greatest employment gains since the demise of domestic and factory work has been in clerical work, especially with public employers. The longest tenured black clerical workers were in the city's public hospital.

Latina females had uniformly shorter tenure and seniority in the hospital labor force. Ninety-three percent of them had been with their hospital employer less than four years. Only one of them had been with her employer eleven years, an extreme in the group: a Dominican who had begun hospital work in the housekeeping department doing "mop and broom" work, she managed to become a clerk. She had spent most of those eleven years doing clerical work yet was unable to upgrade to a better-paying position. At the time of our interview, she had recently achieved a patient advocate position on her *third try* for the vacancy. She was happy about the decision but felt challenged by it because, in her opinion, she was awarded the position only because the department was unable to get anyone else and still deny her the position a third time. It had been made clear to her that she was a "hire of last resort." She believed she could do the job, but the interview, the hiring process, and the department staff's hesitation made her question her assessment of her own skills.

It would be easy to conclude that lack of seniority and short job tenure accounted for low upward mobility. Yet the interviews with the women who had more seniority revealed that they were unable to break into existing internal job ladders as well. Among black clerical workers averaging eight to fifteen years of seniority, many had completed a high school diploma only in the year preceding the interviews despite the hospital's intensive in-house job-training program. When asked why it took her so long to connect to the internal instruction opportunities, one black clerical worker complained that information on training and internal job postings were not uniformly distributed within her department. Participation was limited by hospital practices requiring supervisors to recommend or refer their workers. Some workers were never referred because they were "too essential" or simply not favored. Others may be referred repeatedly because they are favored by department supervisors or there is interest in moving them out of the work area.

Patterns in Job Mobility

After I reviewed the work history the women provided, it became clear that many were involved in horizontal job changes, the types of jobs they held being relatively the same. This was as true of clerical workers as of technicians. For clerical workers, their employers or industries might change, but the job itself remained identical — routine, dead end, predominantly female. Those who worked as technician assistants also held jobs that were relatively equivalent. Unlike clerical workers, technician assistants were tied to the health and hospital industries because their skills were not transferable to other industry sectors. Clerical workers, who had greater choice in other commercial sectors, were not similarly limited as to job location. The job titles and descriptions — tasks added or deleted — changed, but the work and wages were substantially comparable. Three black clerical workers were able to achieve a pay raise and promotion, their vertical mobility the result of the upgrading of that position for the entire department. In fact, as the qualifications were upgraded to a four-year college degree, the black women had to be "grandfathered" in to survive the job restructuring. This increased the friction in that department between the white workers, all of whom had college degrees, and the black women who were then viewed as "less than qualified" affirmative action holdovers. This attitude persisted despite the fact that they had been performing satisfactorily in the department with their white female colleagues for more than a year before the reorganization. One of the black women was completing a four-year degree and would soon be graduating. The second had completed her two-year associate degree and was keenly

aware that she had to return for a four-year degree. The third, in another department, which was being reorganized, was underschooled and a self-reported weak academic student. Though she kept her job title and pay, the duties affording her the greater status and responsibility within the department were written out of her revised job description and handed to a newly minted, college-educated white female whom she was asked to train. These data hold alarming implications for low-income minority women who, as a group, are unable to afford the time and financial costs associated with retooling and returning to school.

Job Leaving

The reasons women left their jobs could not be easily reduced to one variable. Though some single event usually triggered the decision to leave work or to find another job, the women, when pressed, usually put together a more complex scenario. Pregnancy, loss of child care, migration to rejoin a spouse or family, were the common external factors prompting a decision to leave a particular job and reflect women's reproductive and family responsibilities that affect employment. As such, they influence all women, but they have a disproportionate effect on job retention or job leaving for low-wage females simply because of their economic vulnerability to the demands of mothering. The most revealing remark was made by one technician who had been through at least three career changes and several jobs. In her attempt to help me understand what she perceived as a lack of coherence between her jobs and the fields she had passed through, she remarked that the jobs were all the same. In each, she told me, there was no one reason for her decision to leave. A specific event may have been the trigger, but several factors were operating: boredom, lack of future, low wages. The important lesson for her and me was that "there was no reason to stay." This finding reflects the earlier discussion regarding vanquished high school dreams and the lack of career planning opportunities. The women worked at jobs, not careers. The training they managed to gain in short-term programs became "badges" they could pin on job applications. The instruction was horizontal so that the worker could identify a series of skills at which she was proficient, but not hierarchical or cumulative, allowing her to make a qualitative leap to a higher level of reasoning, a higher level of responsibility, or a higher-status job.

For immigrant women the experience was mixed. Some enjoyed a different class position in their country of origin. In the United States they have enjoyed higher wage and income levels relative to those in their home country but have been obliged to downgrade their occupation and class status. No longer the middle-income members or professionals of their society, a few of the women reported having to acclimate themselves to their status as blue-collar workers in U.S. society.

Race and Ethnicity in Hospital Corridors

I asked the black and Latina women to talk about the effect of race and ethnicity on their job experience and their perception of job opportunities within their hospitals. The consensus: "We are the gofers."

> [During] a break, a call comes in for assistance. The supervisor looks around [at] the white women in the room and calls upon me [the black worker] to get up to respond. I was just as tired as they were.

> We [the minorities] were the gofers in our department. Though we held the same position as the other white women in the department, we were always picked on first to run errands or get coffee. They treated us as servants. We were never invited to the office Christmas or birthday lunches.

Women of color reported that they frequently were called on to do more work than the white women in their departments. The dirtiest, most undesirable job was often assigned to them. In medical records, for example, white workers were assigned desk, telephone, or receptionist duties. The Latina worker said that the worst task was in the back room, trying to file medical folders into dusty, overcrowded racks. The room was hot, dimly lit, and the work was physically tiring. She pointed out the back racks to me, asking me to note the color of everyone working there: black. The front section of the same department was occupied by white women at their desks. Blacks and whites all had the same title and position. Aware of this distinction, my respondent fought hard to stay at her desk. Because data entry in medical records was boring, she preferred the receptionist duties at the front desk, but the worker there was not only the newest woman in the department, but also the youngest and prettiest. The male supervisor wanted a "pretty and young" white woman as the face for the department. The Latina knew it, the other black women workers knew it, and the other white women in the department knew it.

Discipline and the Double Work Standard

The black and Latina women reported that they are held to higher standards of accountability and performance with respect to work.

> During my internship, I overheard the head nurse talk about how stupid and dumb those [black] students were. We were every bit as good as the white student interns from the community college. The white student interns were allowed to do more specialized procedures and to learn more. I made sure I got assigned to all the procedures that the white students did and I told my friend to be careful too. When I got my first job somewhere else, I saw a Latina woman technician having difficulty because she had not been trained widely in all of the instruments. It was not her fault.

This young black woman insisted that the training she received at Dimock, her community-based training organization, was rigorous. She reported that she was able to keep up with the white community college interns at the hospital because the Dimock teaching staff had worked them so hard. She was conscious that the white women were all community college trainees while the blacks and Latinas seemed to come from the community-based training agencies. It was equally clear to her that her skills and opportunities were being evaluated on the basis of the perceived quality of her training institution. Despite her superior background and performance, the community college trainees received more attention, more learning opportunities, more status.

Latina women, too, spoke well about their community-based organization training experiences. Where they were learning technician jobs, not clerical skills, the education involved medical terminology and science textbooks. This posed a challenge for women who had problems with the English language, but the support of one another and the teaching staff helped them through it. They said that the faculty at community-based programs were more committed and motivated to training them successfully. The

camaraderie the women forged served them well in class and during internships. One or two attempted to continue their networks outside the classroom and into the hospital surgical areas. There they tried to help each other transfer out of undesirable institutions or undesirable shifts and departments. Because they moved so frequently, it was difficult for the women to maintain the network outside the structure of the program.

Language Harassment

The workers said that they were confronted by colleagues within their departments who felt threatened by those who spoke Spanish among themselves. This form of language harassment was cited by almost every single Latina interviewed. Even when the workers assured their colleagues that they were not talking about them but about other things, the pressure on them not to speak Spanish persisted.

> Last year I started as a secretary. I was Hispanic. Two nurses didn't like it when I talked in Spanish. I got a warning because I was talking in Spanish with another Jamaican nurse who happened to speak Spanish. We were both speaking Spanish but they picked me to discipline. I'm no dummy. They picked on me because I was new and because I was a lowly clerk. The other Jamaican woman was a nurse.

Latina clerical workers especially complained about telephone problems. Callers refused to leave messages or exhibit patience when asked to slow down and to spell the American names clearly. They would not tell the worker directly, but later complained to her supervisor about the bilingual worker's ability to perform the simplest receptionist tasks and duties. The worker felt that the same callers would deliberately rush by difficult names to confuse her. "How would they like it if I asked them to spell Spanish names when they don't speak Spanish?"

Racial Apartheid and Departmental Segregation

It was clear to several clerical workers that some departments were more integrated than others. One woman asked me to walk through the building to let my own eyes reveal to me how race and ethnicity operated. Some departments, those which had higher-paying clerical positions and prettier quarters were simply "all white." When this woman thought of mobility, she looked at the color of coworkers in that department to determine her opportunities. This principle of viewing opportunities through "colored lenses" also operated in the external job market. When two women reported that they simply walked in and completed applications, I pressed them to explain how they decided which companies to approach. They used the presence of other minority workers as an indirect indicator of whether they were welcome as workers.

Racial apartheid also existed in social gatherings and events at the work site. Despite the fact that white colleagues felt isolated by workers who chatted among themselves in a language other than English, they regularly excluded blacks and Latinas from luncheons, Christmas parties, and other celebrations.

Multicultural Competition beyond Black and White Racism

Difficulties in socializing and securing support on the job were also evident to black and Latina women. U.S. blacks held greater seniority and were represented in larger numbers than Latina and black immigrants. Tensions resulting from job competition and language barriers surfaced between minority women too. The perceived common threads

of race and class were important factors in binding women of color within their gender. Thus, while they discussed their differences with white workers and with other women of color, they were less inclined to clarify the latter, feeling uncomfortable about doing so. Whatever differences and tensions Latinas felt with African-American women, or newer immigrants felt with native minority women, it was clear that they perceived the other groups as more likely sources of support than their white colleagues.

Race and Grievance Filing

The majority of the women would not press forward with a complaint or grievance because they saw little reason to do so. The discerned climate of racial hostility mitigated against such an action. Most would approach a supervisor to seek resolution of a problem, but that was viewed as a last resort. This was as true of women in organized-labor settings as of women in nonbargaining unit settings. The union grievance process was regarded as long, tedious, and unproductive. The women believed that outcomes would differ little whether the union or supervisor was involved. Because they were overdisciplined, held to different work standards, and had no recourse, the women were inclined to leave positions at the first opportunity rather than seek a remedy or stay to fight for jobs they viewed as relatively all alike. The reasons to leave or move outweighed the reasons for remaining where they were.

The Social Isolation of Women of Color

These workplace problems and situations are difficult to endure. Where did women seek support if they felt that their supervisors were unapproachable and that they were being ostracized by white peers? Few women mentioned being able to share work-related difficulties with their spouses — "He didn't care, would not understand, or would ask me to quit if work got too demanding of me." Details on the level and quality of social networks conflicted. Some women had ethnic or racial group friends with whom they associated and socialized. Others had no such networks and "stewed" alone. Access to a support group with which one could discuss work matters or problems was quite uneven. Even when I interviewed members of the same racial and ethnic group who worked fairly close to one another in the same institution, they did not know each other. On two occasions I obtained interviews, from different sources, from women who happened to work in the same department. They became aware of each other only as a result of my interviews because they recognized me at the work site and asked whom else I had come to question. These two women had worked together for years without seeking each other out though both had reported being lonely and wanting more companionship on the job.

The important finding here is that social networks operating for information and support for minority women were difficult to identify and, because of two principal issues, more fragile than anticipated. First, social support networks relied on individuals, so the networks were only as strong as their links. People moved regularly, making it difficult for relatively recent employees to maintain a constant connection. Even when the women named specific individuals as responsible for helping them locate jobs or transfers, the resource people they credited came from outside the hospital institution. Second, networks require a certain level of trust. In the workplace setting, the women were reluctant to reveal too much about themselves, their personal lives and problems, to others who are gossipy.

There is tension between groups because one always perceives the other as having

more power. Shift conflicts could partially explain this. My sense, though, was that the hospital culture had a chilling effect on the women. When they attempted to sit together as minorities, they felt singled out and accused of exclusion by white workers, but when white women sat together, there was no such perception. Minorities sitting together was perceived as menacing, and the women felt the stares of their colleagues. When I completed the interviews, one of my overwhelming impressions was of the women's social isolation and need to talk. Because the interviews took longer than planned, the women rarely had the opportunity to speak about themselves and their desires with someone who took the time to listen. The interviews proved therapeutic as the women, listening to their stories, reflecting on their lives, summed up their lessons for themselves.

Hospital Culture and Racial Climate

> A technician entering an operating room overhears the doctor making derogatory ethnic remarks about the Hispanic patient on the table. An intern elbows the doctor, who looks at the technician, stops his comments, but proceeds without apologizing for them.

This is perhaps the most revealing statement about the hospital climate. The women were aware that, at all levels, they were treated differently as workers and as patients because of their race and ethnicity. Some expressed a preference for working at the city's only public hospital precisely because they felt that it offered a slightly better racial climate. Most of its patients were members of a minority, so the personnel presumably bought into the hospital's mission and population.

Race/Class/Gender Harassment

Many of the examples the black and Latina women cited involved their interaction with white female workers, a result of the gender segregation that occurs in the labor force when women find themselves working in all-female occupations. Their interaction with males tended to be with men as doctors and supervisors. Gender segregation also operated in distinct ways in departments such as food services, housekeeping, and direct patient services, where low-income workers were more likely to mingle. However, African-American and Latina women were reminded that, irrespective of class, low-income whites considered them different from white women even when they all worked alongside one another.

> A [white, male] fellow worker refused to help me [a black, female aide] with my cart and materials. He claims I am paid as much as he is so therefore I should do the same work. I know this is true, but I also see how he helps the other white aides with their heavy carts and materials. He treats them with respect and gives them more courtesy.

Racial incidents involving patients had a greater chilling effect because they would bear directly on one's ability to work. Supervisor support in these situations was critical. For example, Grace, a nurse's aide, responded to a patient's signal for assistance. He looked at her and requested that the "other girl," a white aide, be sent to him. Grace told her supervisor, who proceeded to scold the patient. Such supervisors were the exception, according to the women. As a group, they believed that much work had to be done at all levels of personnel to improve the racial climate of the hospital and to change its culture.

Implications for Employment and Training: Policies and Program for Minority Women

Beyond "One Size Fits All" Schooling and Training Policies

The findings on schooling and human capital confirm the research of human-capital labor economists, who argue that it is the lack of schooling and skills which explains the unsatisfactory labor-market participation and lower wage levels of minority groups. The substantial majority of the women I interviewed had only recently achieved their basic high school education. Their lack of skills and credentials explains their inability to secure better than entry-level jobs at the time they first applied to the hospital and to achieve upward job mobility in the internal labor market. Foreign-born and -schooled women, facing problems of accreditation with foreign credentials, found themselves confronting similar structural difficulties of access to an initial job and, once employed, of subsequent access to higher-paid positions. Yet traditional labor economic research understates the complexity of women's schooling and skill gaps. Human-capital theory posits learning and skill deficiencies as the "cause" of unequal labor-market success and proposes schooling and vocational training as the "remedy" so that workers can attain labor-market success. Their personal situations suggest that the schooling and skill gaps of these women were quite diverse. Some required substantial learning to remedy long-standing reading and writing deficiencies, while others required brushing up on concrete vocational skills tailored to their positions.

Some of the foreign-born and -schooled women were already quite competent but needed an alternative mechanism to demonstrate their skills rather than repeating an educational program that would provide them with paper accreditation but little new knowledge. It is clear that any training remedy set up to increase the knowledge and human capital of the women has to take into account the diversity of their needs as well as the enormous opportunity cost associated with skill upgrading for this economically vulnerable group, namely, the expenses associated with training, ranging from tuition and fees to child care and travel. In addition to enormous constraints on travel to classes and tuition payments, the women had to cope with "time poverty" from work and home as well as physical exhaustion. Their inability to find relief from their "second-shift" home responsibilities depleted the time available to fulfill their homework assignments and reading even when they attempted to study against all odds. In addition, the issue of reward for their extra effort to narrow their schooling and skill gaps has to be examined in future research. Without a substantial increase in the quality of the degree attained or the training, it is not clear that the women would gain a substantial increase in earnings.

Returning to school at the lower level of skill training sent mixed messages to the women. Human capital and schooling, as a variable assumed to increase wage levels, did not operate as they expected. Immigrant women found themselves in the same jobs, at comparable wage levels, as those of U.S. black and Latina women with superior U.S. schooling and English-language skills, irrespective of whether they held a GED, a high school diploma, had some community college, or were in union or nonunion employment settings. The variables of age and more or less experience in the job market, similarly, had no effect on raising their wage levels, as they might have expected and as traditional labor-market theory suggests. The variables linked to labor-market success

did not improve their access to better-quality jobs. Whether young, under thirty, or mature, whether schooled in the South or in Boston public schools, whether with or without work experience at the time of their first hospital job, black and Latina women found their way to the same jobs and wages. How, then, are women to remain motivated to invest time and money in schooling? The findings suggest that attention to increasing the human-capital skills of black and Latina workers will have to be flexible in design and academic content and in their ability to be creative in allowing alternative ways to earn degrees for existing skills. Most important, the findings suggest that we must require greater emphasis on job placement to ensure that returning to school is the path to helping these women locate jobs outside the segregated tiers where they are already concentrated.

Expanding Job Search Strategies and Networks

The foregoing makes evident the pressing need for blacks and Latinas to identify new strategies and networks to connect them to jobs and support them, once they are in jobs, to achieve upward mobility. Employing the job search strategies and networks of kin and friends, the women wound up in the usual slots — segregated, low-wage jobs. In limiting their search to employers and jobs that would allow them to meet others like themselves, they were restricting their opportunities to the lowest job levels and wages, where minorities are traditionally located. The work of William Julius Wilson posits that it is the isolation of African-Americans in the inner city which locks them into networks that don't lead anywhere and suggests that we must find ways to break that isolation.[5] Black and Latina women discover themselves in a type of "American apartheid," which isolates them from mainstream ideas, housing, schooling, and jobs.[6]

My expectation, therefore, was that these blacks and Latinas would be more successful in locating jobs outside the traditional minority job sectors when they used job placement networks rather than kin and friends. The most common job placement strategy involved the services of community-based training organizations. The results for blacks and Latinas, in terms of the types of job, employer, and wage levels, demonstrate that community-based organizations (CBOs) had no greater success than the women themselves in gaining access to better-quality positions. The failure is partly the fault of the funding structure of community-based training organizations discussed earlier. They are funded to provide the fastest job placement possible and discouraged by their funding structure from providing longer-term training or services that might yield better opportunities for the women. At different points in their historical development, CBOs have been more successful at winning access for their constituents. Research to reevaluate the role of these programs and to assess ways to create funding and performance policies for them so that they can better wage this battle is needed.

Mobility in Internal Labor Markets

The inability of the women to achieve mobility is explained by their limited schooling and human capital. But still unexplained was the inability of internal policies and programs to reach and connect the women to training and jobs. For most of the Latina and immigrant women, their lack of job seniority may explain the failure of traditional networks to communicate with them, since most had been in their employment a little longer than two years. The more extreme example of the African-American women who were allowed to work from five to eighteen years with little attempt to connect them to a basic

high school equivalency training program has already been cited. Another disturbing trend was the dampening effect of the hospital racial climate and culture on the aspirations of the women. Most distrusted their supervisors and did not believe that internal transfer and promotion policies worked for them. The responsibility to support employees has traditionally fallen on human resource personnel and in-house training programs, but according to information from the interviews, the ability of these to reach, provide services for, and support women of color is mixed or nonexistent. Most of those interviewed relied on the services of community-based training organizations at least once and, in a few cases, more than once. Such unmet needs for support of minority women workers provide an opportunity for these organizations to consider coalition work with employers and unions so that they may continue to mentor and encourage their constituents after training and job placement. Some of them will welcome the opportunity to continue their role of providing remedial skill development and vocational training to workers in an employment setting.

It is important to note that the availability of community-based organizations and services is not uniform throughout minority communities. The organizational infrastructure in the African-American community is better developed because it has been in place longer and therefore has had the opportunity, historically and economically, to develop and strengthen the programs. Other populations have less developed and unevenly developed community-based networks, forcing constituents to seek organizations outside their traditional cultural niches. To their credit, African-American organizations have made great strides in reaching out to diverse constituents. The CBOs are increasingly sophisticated in their ability to deliver services to linguistic minority immigrant groups, black and Latino. This reflects their ability to manage the latest wave of immigrants and to adapt to new constituents and new market opportunities, for instance, nonprofits. The Latina women trained as surgical technician assistants praised the Dimock Training Center program highly and recognized the efforts of that historically African-American organization to meet their needs. It is worth noting that because they were warmly welcomed and satisfied with their jobs, they actively recruited and referred Latinas from their own communities to Dimock.

As community-based organizations engage in adult training, they face two important challenges. First, with increasing reliance on diplomas and credentials that are transferable to other learning institutions, CBOs must gain accreditation as postsecondary institutions or enter into formal arrangements with a certified entity. The women themselves recognized the strength and superiority of the training they received from these organizations. Yet strong training did not withstand long-held prejudices within the hospital industry, which favored diplomas from traditional universities over certificates from CBOs. Community colleges are also competing for enrollments in short-term skill training in nondegree certificate programs. The contest between community-based organizations and higher education institutions is likely to increase. Some CBOs are trying to retain their market niche to service traditionally displaced student populations by themselves securing accreditation as higher education institutions. In Massachusetts, the Dimock Training Center has sought accreditation, as has Action for Boston Community Development's Urban College. For the moment, public higher education institutions have better funding and facilities though a less favorable track record in contacting and retaining minority populations in Massachusetts. Community-based organizations have to provide better evidence of their past performance and strive to compete more effectively to retain their clientele by addressing the issue of transferable, accredited diplomas.

The second challenge which community-based organizational training programs must confront is that of quality job placement. Funders, government sponsors, and their community constituents hold CBOs, which were created historically to empower minority communities and to play an active advocacy role, to a standard of accountability different from the one they demand from higher education and adult training institutions. CBOs must continue to pioneer the efforts of blacks and Latinos to overcome inequality by increasing the ability of their constituents to access quality jobs with good wages and benefits. A great deal of the success of U.S. blacks in achieving schooling and labor-market gains resulted from the efforts of community-based initiatives and organizations. These endeavors significantly narrowed the schooling gap for African-Americans between the demise of Jim Crow segregation in the South and the advent of the civil rights era. If the jobs into which trainees are placed are already available to black and Latina women, why fund a community-based organization to place them in jobs they can acquire on their own? The greatest contribution of CBOs has been in helping to break through barriers to new economic jobs and opportunities. Funders' efforts to limit that historic role and responsibility through funding and job placement policies that do not serve the best interests of minority women should be resisted by all concerned with improving the economic well-being of minority workers.

Improving Job Readiness: Boston Public Schools

To expand services and improve their coordination for workers on the job is important but misses a critical point offered by the women. Making choices about work and careers has to begin at a young age, before the women become victims of early pregnancy and marriage. It was the perceived absence of opportunities which led to many early pregnancies. The Boston public school system has made efforts to introduce vocational apprenticeships and training through the Private Industry Council and other magnet programs. Yet there is clearly a problem of quality. Students with a high school diploma were not job-ready, had no skills to effect a transition into a formal labor market, and were ill prepared for the demands of the labor market and college programs. Given the amount of foreign schooling the women experienced, it is unfair to attribute all language and skill deficiency problems to the Boston schools. Still, it remains the responsibility of those institutions to provide services to an increasingly diverse linguistic population and the record, on this front too, is unsatisfactory, according to the women who graduated from them. More disturbing is the fact that nonimmigrant, English-language-dominant women from Boston schools fared no better in the job market. The women asked for more help in career planning and for quality schooling so that they could acquire skills marketable in the workplace as well as in a college setting.

What Can Hospital Employers Do?

My comments thus far have centered on the schooling and skill gaps that trouble employers as much as they do many other citizens. Employers are already working closely with public schools to remedy quality issues among graduates. It is appropriate to consider what internal actions employers might take to improve the upward mobility of entry-level black and Latina women. The women suggested several.

Make hiring and promotions easier. Employers can increase efforts to recruit and hire minorities. The majority of the women gained a hospital placement only after an agency or specific

individual interceded on their behalf. Their applications went unanswered most of the time. Hospitals can monitor the racial segregation of their internal departments. Finding black and Latina concentrations in specific job categories or only in specific departments suggests that efforts to diversify are in order. Equally, monitoring disciplinary actions, suspensions, and failure to transfer/promote would suggest departments and supervisors in need of attention. It was unclear to the women why they needed intervention to get a job interview or a job in the lowest tier.

Train supervisors. In a hospital climate and culture dependent on referrals and protection, training supervisors about racial issues is critical. The women felt isolated, without peer or mentor support, and vulnerable against doctors, nurses, and the patients themselves. Distrustful of the grievance procedures and internal systems, they were more likely to leave work than seek resolution, which leads to high staff turnover and problems associated with low morale and performance. Skills in handling issues of diversity should be required along with skills in supervision, mediation, and management. In most cases, the workers simply wanted to be valued and treated with respect. Given their examples, this was a modest demand.

Provide paid release time for improving skills. Department budgets should include compensation for employees released to training so that other workers are not penalized for their peers' absence through an inadvertent work overload. Supervisors would be less inclined to disapprove of an employee's participation in additional schooling and training if money was available to hire labor during the employee's absence. Some departments have greater flexibility in providing release time than others, placing employees in housekeeping, patient services, and related urgent-care situations at a clear disadvantage. Surgical technicians, for example, must remain in an operating room for the entire length of a procedure, even when that operation runs over their shift or working hours. In some departments, workers rotate difficult midnight shifts among employees. Such rotations and departmental demands prevent employees from committing to a fixed time schedule for a class. Paying workers to attend class would help supervisors release them and provide an incentive to make time for learning.

Availability of paid work release provides relief for women outside the workplace as well. They suffer greatly from time poverty, working full-time jobs and spending the remainder of their days trying to raise their children substantially alone. Having a partner provided no relief from second-shift housewife duties. As was evident from the older black female group, the major obstacle to promotion was lack of a basic high school diploma. Most had been unable to tend to basic requirements through lack of information, outreach, and opportunity. Unable to manage release time from their parental obligations at home, many worked in departments that also had difficulty releasing them. Women reported that in-house and off-campus training opportunities, which required them to pay and attend on their own resources and time, were not really available to them. They had had neither the resources nor the time to do so. Participation in school and training increased significantly when the institution paid for the training rather than reimbursing students afterward; paid release time was provided for employees during their regular working hours; training was accessible on site or close by; and training was relevant to performance of their jobs. The promise of college credit or other credentialing made the training even more appealing. Availability of paid training and paid release time also made it easier for women to persuade a reluctant partner to cooperate.

In addition to workplace barriers to mobility, I discussed external barriers to mobility, the most important being second-shift responsibilities. A full description of discussions in interviews regarding spousal/partner support and family/community support networks is beyond the scope of this article, but I want to reiterate that access to support is critical for all women, particularly low-income blacks and Latinas, if they anticipate long-term survival in the workforce. Middle-income and professional women, who have greater resources with which to purchase services necessary to their remaining active in the workplace, may also have the advantage of a flexible work schedule that permits them to meet second-shift responsibilities easily. Among lower-skilled women, clerical workers had the advantage in second-shift management, sometimes including the option of bringing a child to work or leaving early without causing disruption. Women in direct patient services, for example, in operating rooms, were not likely to have the same flexibility nor to be treated as sympathetically by workers and supervisors when the second shift intruded on the workplace. The most successful of the black and Latina women I interviewed, in terms of schooling and ability to focus on securing job mobility in the hospital, were precisely those with supportive partners who encouraged them and shared child care. Of the thirty I interviewed, only four fit this category, one of whom was a newlywed who was under pressure to bear children. The majority of the women had a changing cast of partners, partners who were altogether absent, or partners who were intolerant of any activity that might infringe on the home.

Women who sought support in kin or community networks without the partner found that the relationships were fragile, subject to changing quickly, demanding reciprocity they could not always deliver, and otherwise fraught with difficulties. Some networks were not cost effective because the women had to expend more time and resources on them than they received. Relying on such networks in an era of migration and economic restructuring shakes some assumptions that earlier research on low-income communities held to be critical for the survival of women and their families. The increasing economic vulnerability of low-income families is having an impact on kin networks, so it may not be structurally practical to assume that minority women can rely on them as they did in the past.[7] The meltdown of support networks, as the women conveyed it to me, did not necessarily reflect a pathological breakdown in culture or tradition. The sense I got from them was that the growing economic inequalities of the labor market over the past two decades was placing unprecedented strains on families. Even when they wanted to continue the networks, they were more than ever unable to do so.

Being female, a single parent, and a woman of color stand as the best predictors of poverty, child poverty, and inequality in the United States today. If we are to help women stay active in the labor force and secure jobs with a living wage for themselves and their families, we must pay increasing attention to narrowing schooling and skill gaps for minority women. We must help them negotiate the career ladders in their internal labor markets, providing them with the external supports necessary to balance their family and work lives. Paramount among these, the thirty women stated time and again, was the need for quality, affordable, accessible, and multicultural child care. We must not assume that all service-sector jobs offer low wage and status, for many of these women were paid well above minimum wage even in semiskilled entry-level positions. Nor should we err in assuming that one-size-fits-all training programs benefit all entry-level workers. Some of my group had distinct and wide-ranging skill and school levels. In an era when most American households require two wages to sustain a family, we must extend to low-income working mothers extra subsidies and supports to assist them in

staying competitive in the workforce and allowing them to retool regularly to perpetuate job gains. The alternative, public welfare, is as unacceptable to the public as it is to the women I interviewed. They worked very hard to escape the poverty and hopelessness that welfare dependency guaranteed them.

Notes

1. Françoise J. Carré, "Employment Trends in the Allied Health Professions," paper prepared for the Worker Education Program Evaluation Project, University of Massachusetts Boston, Labor Studies Program, April 1993.
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4. Michael J. Piore and Peter B. Doeringer, *Internal Labor Markets and Manpower Analysis* (Lexington, Mass.: D. C. Heath, 1971).
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6. Douglas S. Massey and Nancy A. Denton, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge: Harvard University Press, 1993).
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Allied Health Professions in the Health-sector Job Structure

Françoise J. Carré, Ph.D.

This article reviews the characteristics of allied health professions in the U.S., Massachusetts, and Boston health sectors. These occupations are considered in the broader context of the multitiered job structure of the health sector and their gender and ethnic composition. The discussion includes surveys of vacancy rates and wage levels for selected allied health professions in Massachusetts hospitals. The article concludes with a more detailed, albeit national, picture of these occupations in the hospital sector per se, their demographic composition, and earnings level.

During the late 1980s and early 1990s, hospitals in Boston and other parts of Massachusetts experienced shortages in several allied health professions. This prompted a call for expanding and making more accessible the existing allied health degree programs.[1] The shortages also raised hopes for the development of future career opportunities for the large number of workers currently employed in entry-level positions, many of whom belong to racial/ethnic minorities. As one local report noted, "Over 80 percent of Boston residents who are health care employees are in entry-level jobs. Only one percent of Boston public school graduates have entered health professions since 1978, due to numerous gaps in the public education–through-four-year-college-degree programs."[2]

Allied health professions are hierarchically above but proximate to the numerous entry-level positions held by minorities. As such, they seem to be ideal occupations for professional programs targeted at training minorities for occupations in which there will indeed be numerous opportunities in the near future.

This article provides a national, statewide, and local picture of the allied health professions. Its goals are to define allied health professions; to locate them in the occupational hierarchy of health-sector employment (tiers of jobs); to describe the current allied health workforce in the United States, Massachusetts, and Boston; and to provide some details on a few of the occupations at the bottom of the health-sector employment structure, where workers who are likely to be recruited for, and derive benefit from, training are found.

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Definition of Allied Health Professions

In accordance with professional associations and other groups, I define allied health professions as falling into two broad groups. The first consists of semiskilled health technician positions that require some training, either general (high school degree) or specific (a few community college courses). These include such positions as physical therapy assistant, laboratory technician assistant, operating room technician (prepares the operating room and hands doctors and nurses surgical instruments), and electrocardiographic (EKG) technician.[3]

The second set consists of skilled technical allied health occupations, which require anywhere from two to four years of specialized college courses and passing a licensing examination. Historically, these occupations were learned on the job, but in the most recent past professional associations have formed and have established licensing requirements.[4] It is not possible for a worker in the hospital hierarchy to be promoted into these occupations without formal education and an apprenticeship period. Only when a technique is so new that no curriculum exists can they move into it without formal training.[5] New occupations in this category include, for example, radiological technician, respiratory therapist, ultrasound technician, and radiation therapy technician.

A number of these occupations are split between professional-level (four-year) and assistant-level (two-year) training. Training programs aimed at facilitating promotion target the assistant level of allied health professions because it is most proximate to entry-level occupations (see below, Tiers 2 and 1) and because the formal education requirements for assistant positions are lower.

Within these broad guidelines, industry observers define, variously, the specific occupational titles that belong to the allied health field. The occupations to which I devote particular attention include:

- radiological technologist (or technician)
- occupational therapist and assistant
- physical therapist and assistant
- respiratory therapist and assistant
- medical technologist and medical laboratory technician.

The employment statistics describing these occupations vary in level of detail depending on whether they come from national employment surveys such as the *Current Population Survey* or narrower industry surveys such as that conducted by the Massachusetts Hospital Association.

Projections

Allied health occupations have been perceived as opportunities for future employment because they have grown in the recent past and are projected to grow further in coming years. National projections to the year 2000 show steady growth in several of these professions. Projected rates of growth from 1988 to 2000 were 66 percent for radiologic technologists and technicians, 59.9 percent for medical record technicians, 57 percent for physical therapists, 52.5 percent for physical and corrective therapy assistants, 48.8 percent for occupational therapists, and 44.7 percent for occupational therapy assistants and aides.[6]

For Massachusetts, 1991–2005 industry projections put the offices of health practitioners, nursing homes, hospitals, and other health services among the activities that will add the largest number of new jobs to the state's economy. Employment projections point to significant growth rates in selected allied health occupations: 60.6 percent for radiologic technologists and technicians, 36.8 percent for medical record technicians, 51.8 percent for physical therapists, 40.5 percent for physical and occupational therapy assistants, 41.3 percent for occupational therapists, and 36 percent for dental hygienists.[7]

Composition of the Health Sector

Here, consistent with other reports,[8] I define the health sector as comprising the following subsectors: hospitals, nursing and personal care facilities, outpatient care facilities, and other health and allied services.[9] Hospitals employ the largest number by far, in 1990 accounting for 75.6 percent of health-sector employment nationally, 78.7 percent in Massachusetts, and 78.8 percent in Boston.[10]

Employment Structure in the Health Sector

Roughly speaking, health-sector jobs can be arrayed along a four-tier hierarchical structure. Tier 1, at the bottom, includes service and blue-collar jobs such as nurse's aide and kitchen and housekeeping workers. Tier 2 comprises clerical workers and a few technical assistant workers. Tier 3 comprises skilled technicians such as radiologic technicians and licensed practical nurses. Tier 4 consists of professionals such as registered nurses and physical therapists as well as physicians and administrators (some observers place the latter two separately, in a Tier 5).[11]

Thus, allied health occupations straddle Tiers 3 and 4. As a group, these occupations do not fit neatly into the existing occupational hierarchy of the health sector because they are relatively new, have an evolving scope of responsibilities, and their emergence is somewhat driven by technological innovations. Most fall into Tier 3, but therapists, particularly those requiring a four-year and beyond college degree, fall into Tier 4. Workers in Tiers 1 and 2 represent the pool of potential recruits for training programs leading to the beginning rungs of allied health professions.

Statistics permit an approximation of the evolution over time of the health-sector occupational structure. Table 1 provides estimates of the relative sizes of Tiers 1, 2, and 4 in the nation, in Massachusetts, and in Boston for the health sector as a whole.[12] I describe allied health occupations separately below because they are not adequately captured by Tier 3 employment, which also includes nursing occupations.

Nationally, statewide, and locally, the health-sector employment structure displays a significant concentration of employment in the top and bottom tiers, 4 and 1, which account for about two-thirds of employment nationally, statewide, and locally. Perhaps to a greater degree than other large sectors in the economy, for example, manufacturing, the health sector presents a bimodal structure of jobs because it employs large numbers of professionals and paraprofessionals. A great dispersion of skills and earnings results from the structure within the sector.

Allied health professions, straddling Tiers 3 and 4, are a set of occupations that provide one of the few possibilities for career ladders in the health sector because they are

health-related jobs which current employees can obtain through workplace-based training and education in the health field. They have the potential to be a path for internal vertical movement of the health-sector workforce. Tier 1 workers, with seniority and additional education such as a high school degree, can be promoted to Tier 2 jobs. Once there, they form a substantial pool of potential recruits for apprenticeship programs for allied health jobs in Tier 3.

The 1990 state and local employment picture in the health sector indicates a somewhat greater share of professional and managerial employment — 40.5 and 42.3 percent, respectively — than in the nation as a whole — 39.3 percent. The same pattern holds true for hospitals, which account for almost 79 percent of health-sector employment in both Massachusetts and the Boston urban area and for 76 percent of health employment in the nation. Tier 4 workers account for 43.1 percent of total employment nationally, 43.5 percent statewide, and 43.8 percent in Boston (see Table 2). Hospitals appear to employ relatively fewer Tier 1 workers (4 to 6 percentage points less) and, correspondingly, more Tier 2 and Tier 3 workers than the health sector as a whole. This distinction reflects the fact that hospitals provide specialized medical care while other segments of the sector, such as nursing homes and personal care facilities, provide a broader range of less technical services. We can expect to find both a greater pool of Tier 2 workers and more opportunities for Tier 3 employment in hospitals than in other subsectors.

Table 1

Lower and Upper Tiers of the Health Sector
(Occupational Structure: Number and Percentage of Total Employment)

	United States	Massachusetts	Boston (PSMA)
Tier 4: Professional and management workers	1,617,357 39.3%	65,004 40.5%	36,998 42.3%
Tier 2: Office and clerical workers	687,454 16.7%	28,440 17.7%	16,256 18.6%
Tier 1: Service and blue-collar workers[a]	1,179,897 28.7%	43,434 27.1%	21,684 24.8%
Total Employment	4,110,736	160,577	87,373

Source: U.S. Equal Employment Opportunity Commission, *Job Patterns for Minorities and Women in Private Industry, 1990* (Washington, D.C.: U.S. Government Printing Office [hereafter GPO], 1990).

Note: The health sector includes SICs 805, 806, 808, and 809 (see text). Tier 3 employment is not reported because it could not be computed accurately (see text). As a result, the tier worker figures do not add up to total employment.

[a] Blue-collar workers include craft workers, operatives, and laborers. There are few craft workers in the health sector, so little accuracy is lost by including them in Tier 1.

Racial/Ethnic Distribution in Tiers 1 and 2 Employment

Large pools of workers in Tiers 1 and 2, where the greatest numbers of minority workers are employed, are poised for potential advancement to Tier 3 positions with appropriate education and apprenticeship. In the health sector as a whole, minorities tend to be overrepresented in Tier 1 employment relative to their share of total employment, an indication of their concentration at the bottom of the job structure. This pattern holds true for the nation, for Massachusetts, and particularly for Boston (see Table 3). Black workers' share of Tier 1 employment is about twice their share of total employment. Non-Hispanic blacks account for 29.4 percent of Tier 1 employment in the nation, and for 18.8 and 28.6 percent in the state and city, respectively. In contrast, the non-Hispanic black share of total, all tiers, health-sector employment is 15.6 percent nationally, 8.6 percent in Massachusetts, and 12.3 percent in Boston.

The representation of Hispanics in Tier 1 jobs is about twice as high as their share of total health employment. Hispanics account for about 7 percent of Tier 1 employment nationally, statewide, and locally. In comparison, the Hispanic share of total health-sector employment is 4.6 percent nationally, 2.9 percent statewide, and 3.1 percent in Boston. Although they are present in large numbers in Tier 2 employment, Hispanics are not as highly concentrated there.

Table 2

Lower and Upper Tiers of the Health Sector
(Occupational Structure: Number and Percentage of Total Employment)

	United States	Massachusetts	Boston (PSMA)
Tier 4: Professional and management workers	1,339,513 43.8%	55,011 43.1%	30,713 43.5%
Tier 2: Office and clerical workers	554,935 17.9%	25,053 19.8%	14,065 20.4%
Tier 1: Service and blue-collar workers[a]	711,242 22.9%	25,874 20.5%	13,291 19.3%
Total Employment	3,107,429	126,324	68,816

Source: U.S. Equal Employment Opportunity Commission, *Job Patterns for Minorities and Women in Private Industry, 1990* (Washington, D.C.: GPO, 1990).

Note: SIC 806. The health sector includes SICs 805, 806, 808, and 809 (see text). Tier 3 employment is not reported because it could not be computed accurately (see text). As a result, the tier worker figures do not add up to total employment.

[a] Blue-collar workers include craft workers, operatives, and laborers. There are few craft workers in the health sector, so little accuracy is lost by including them in Tier 1.

In the hospital sector per se, minorities are significantly overrepresented in Tier 1 employment and somewhat overrepresented in Tier 2 employment as well (see Table 4). Non-Hispanic blacks represent 28 percent of Tier 1 hospital employment in the United States as a whole, almost 19 percent in Massachusetts, and 29 percent in Boston. Their share is more than twice as high as that of black workers in total hospital employment nationally, regionally, and locally. Black workers are slightly overrepresented in Tier 2 employment as well.

Hispanics account for about 7 percent of Tier 1 employment in hospitals nationally, statewide, and locally — almost twice their share of total hospital employment. Hispanics are also slightly overrepresented in Tier 2 employment. Asian workers are not significantly overrepresented in Tier 1 and are, if anything, underrepresented in Tier 2 employment relative to their share of total employment. Numbers for Native American workers are too small for valid comparisons of employment share.

Racial/ethnic minorities, then, may benefit from workplace-based training programs because they concentrate in Tier 1 and Tier 2 occupations, are underrepresented in allied health occupations and are in higher education programs for health professions.

Demographic Characteristics of Workers in Allied Health Occupations

To describe the allied health professions, I use the 1990 census figures for Massachusetts and the city of Boston itself from the *Equal Employment Opportunity File,* which reports numbers of workers employed in selected occupations regardless of the

Table 3

Minority Representation in Tiers 1 and 2 of the Health Sector

	United States (percentage)	Massachusetts (percentage)	Boston (PSMA) (percentage)
Tier 1: Service and blue-collar workers[a]			
Non-Hispanic whites	59.7	72.0	61.2
Non-Hispanic blacks	29.4	18.8	28.6
Hispanic	7.6	7.1	7.6
Asian	2.7	1.8	2.5
Native American	0.5	0.4	0.2
Tier 2: Office and clerical workers			
Non-Hispanic whites	76.9	86.0	80.1
Non-Hispanic blacks	15.3	9.5	14.1
Hispanic	5.6	2.7	3.3
Asian	2.0	1.8	2.5
Native American	0.3	0.1	0.1
Total Health Sector Employment			
Non-Hispanic whites	75.0	86.4	81.9
Non-Hispanic blacks	15.6	8.6	12.3
Hispanic	4.6	2.9	3.1
Asian	3.6	1.9	2.6
Native American	0.3	0.1	0.1

Source: U.S. Equal Employment Opportunity Commission, *Job Patterns for Minorities and Women in Private Industry, 1990* (Washington, D.C.: GPO, 1990).

[a]The health sector includes SICs 805, 806, 808, and 809 (see text).

industrial sector in which they work.[13] Needless to say, most are in the health sector. The occupations reported below encompass most of these professions but may aggregate individual occupations. For example, the "other health technicians" category includes medical technologists and medical lab technicians, two occupations for which detail would be useful.[14]

Gender Composition

Like many health-related occupations, except for physicians and administrators, allied health is a field dominated by females. Nationwide, they account for highs of 98.4 percent among dental hygienists and 93.5 among speech therapists. They are concentrated to a lesser extent among respiratory therapists at about 60 percent. Women workers fill 72.3 percent of radiologic technician positions. These numbers are substantially higher than the female share of all occupations in the civilian labor force nationwide of about 46 percent. This pattern differs little in Massachusetts, where women also predominate primarily among speech therapists (93.5 percent) and dental hygienists (98.4 percent) and least among respiratory therapists (62.6 percent). Radiologic technicians are 81.9 percent female.

However, women have much less representation in the allied health workforce of the Boston metropolitan area, a situation peculiar to employment in the urban setting. They account for no more than 89.7 percent of speech therapists and for a low 56.3 percent of the "other therapist" category. Male workers account for more than 30 percent of

Table 4

Minority Representation in Tiers 1 and 2 of the Health Sector

	United States (percentage)	Massachusetts (percentage)	Boston (PSMA) (percentage)
Tier 1: Service and blue-collar workers[a]			
Non-Hispanic whites	61.1	72.7	60.5
Non-Hispanic blacks	28.1	18.8	29.0
Hispanic	7.8	6.4	7.4
Asian	2.6	2.0	2.9
Native American	0.4	0.1	0.2
Tier 2: Office and clerical workers			
Non-Hispanic whites	77.6	86.1	79.5
Non-Hispanic blacks	14.9	9.5	14.5
Hispanic	5.4	2.6	3.4
Asian	1.8	1.8	2.6
Native American	0.3	0.1	0.1
Total Health Sector Employment			
Non-Hispanic whites	78.0	88.0	83.2
Non-Hispanic blacks	13.8	7.5	11.1
Hispanic	4.4	2.4	2.8
Asian	3.5	2.0	2.8
Native American	0.3	0.1	0.1

[a]SIC 806.

employment in five allied health occupations, whereas only in one occupation, respiratory therapist, do women have that distinction, both nationally and statewide. In Boston, women fill only 60.7 percent — more than 10 percentage points below the national average of 72.3 percent — of radiologic technician positions. Given that women in Tier 2 concentrate in clerical employment, future training of Tier 2 workers may result in an increase of females in allied health occupations in Boston as well. It is possible that Boston area employers, mostly large teaching private hospitals, hire relatively more allied health workers with B.Sc. degrees, which few women earn.

Racial/Ethnic Composition

Non-Hispanic white workers dominate employment in allied health nationally, statewide, and in the city of Boston (see Table 5; also see Tables 8 and 9 in "Employment Trends in the Allied Health Professions" for U.S. and Massachusetts data).[15] In the United States as a whole, non-Hispanic black female workers account for 16 percent of dietitians and 13.5 percent of health record technicians. Black males reach a high representation of 4.4 percent among respiratory therapists. Non-Hispanic black females account for 5.4 percent of the civilian labor force and males for 4.9 percent. Among radiologic technicians, black women fill 5 percent of positions and black men 2.7 percent. In Massachusetts, black workers are even less of a presence, forming a smaller share of the state's workforce than of the U.S. workforce — 4.2 percent (2.1 percent each for males and females — of the Massachusetts workforce as compared with 10.3 percent of the nation's workforce). In the state, black women account for 7.1 percent of health record technicians and 6.8 percent of dietitians but only 0.4 percent of radiologic technicians. In the city of Boston, non-Hispanic black women fill positions as health record technicians (29.9 percent), clinical lab technicians (26.3 percent), and dietitians (25.4 percent), but they are virtually nonexistent in the ranks of radiologic technicians. Non-Hispanic black females account for 10.8 percent and non-Hispanic black males for 10.3 percent of the civilian labor force.

The pattern of Hispanic allied health workers in Massachusetts and Boston differs from the national picture. Nationwide, Hispanic women account for 6.2 percent of health record technicians, 5 percent of other health technicians, and 2.5 percent of radiologic technicians. Hispanic males represent 3 percent of radiologic technicians. In contrast, in Massachusetts, Hispanic women represent 5.1 percent of dietitians, 3.3 percent of health record technicians, 3.2 percent of speech therapists, and 1.2 percent of radiologic technicians. Hispanic women are particularly concentrated among dietitians, considering that their share of the state's total workforce is 1.5 percent. Hispanic males, 1.9 percent of the state labor force, comprise about 1 percent of Massachusetts employment among dietitians, clinical lab technicians, other health technicians, and radiologic technicians. In Boston, Hispanic female workers are "overrepresented" in a few allied health occupations relative to their 3.8 percent share of the city labor force. They are more prominent among speech therapists (28.2 percent), dietitians (13.8 percent), and health record technicians (12.9 percent). Hispanic males, 4.9 percent of the state labor force, account for 5.4 percent of dietitians, 4.5 percent of speech therapists, and 4 percent of clinical lab technicians. Hispanic men and women are almost entirely absent from radiologic technician employment.

Table 5

City of Boston Racial/Ethnic Composition of Allied Health Occupations

	White Non-Hispanic Male (percentage)	White Non-Hispanic Female (percentage)	Black Non-Hispanic Male (percentage)	Hispanic Male (percentage)	Hispanic Female (percentage)	Asian Male (percentage)	Asian Female (percentage)	Total
Dietician	9.1	34.8	4.3	5.4	13.8	0.0	7.2	552
Respiratory therapist	23.1	50.6	9.0	0.0	0.0	0.0	0.0	157
Occupational therapist	18.8	81.3	0.0	0.0	0.0	0.0	0.0	128
Physical therapist	25.6	68.7	3.5	0.0	0.0	2.2	0.0	227
Speech therapist	5.8	53.2	0.0	4.5	28.2	0.0	0.0	156
Other therapists	41.6	43.3	2.0	0.0	0.0	0.0	3.4	239
Clinical lab technician	11.8	37.0	8.3	4.0	2.4	7.3	2.4	1,090
Dental hygienist	11.3	71.5	0.0	0.0	0.0	7.3	9.9	151
Health record technician	17.0	34.0	0.0	0.0	12.9	3.1	3.1	194
Radiologic technician	15.2	58.2	24.2	0.0	0.0	0.0	2.5	244
Other health technicians	27.3	43.2	4.0	2.9	6.9	1.8	1.0	1,464
Civilian Labor Force	33.2	31.4	10.3	4.9	3.8	2.5	2.1	314,997

Source: U.S. Department of Commerce, Bureau of the Census, *1990 Census of Population and Housing, Equal Employment Opportunity File,* January 1993.

Note: Because their numbers are so small, Native Americans and "other" race workers are not reported. In the U.S. civilian labor force, "other" males and "other" females account for 0.4 percent each.

Nationwide, female Asian workers, 1.3 percent of the labor force, account for 4.6 percent of clinical lab technicians and 3.9 percent of dietitians. Asian men, 1.5 percent of the labor force, account for 1.4 percent of clinical lab technicians. Men and women together are only about 1 percent of radiologic technicians. In Massachusetts, Asian women, 0.9 percent of the labor force, account for 3.2 percent of dietitians and 2.7 percent of clinical lab technicians. Asian men, 1.1 percent of the labor force, represent 2.3 percent of clinical lab technicians. Fewer than 1 percent of radiologic technicians are Asian males and females. Asian workers have a greater presence in Boston allied health employment. Asian women — 2.1 percent of the labor force — reach 9.9 percent of dental hygienists, and 7.2 percent of dietitians. Males — 2.5 percent of the labor force — account for more than 7 percent of employment among clinical lab technicians and dental hygienists. Asian women comprise 2.5 percent of radiologic technicians; Asian males are totally absent from this occupation.

Allied Health Professions in Massachusetts and Boston

Hospital Vacancy Rates

In the late 1980s and early 1990s, Massachusetts hospitals experienced high vacancy rates for allied health professions. The vacancy rate is defined as the ratio of vacant full-time equivalents to the total number of budgeted full-time equivalents for a position. These vacancies, combined with anticipation of a limited number of graduates from regional allied health degree programs, spurred worries about sustained future labor shortages as well as an interest in looking to Tier 2 workers as a pool of potential trainees for some technician occupations. A review of results from Massachusetts Hospital Association (MHA) periodic surveys of member hospitals, which focus on more specialized therapist occupations than those discussed above, shows that the hospital association selects a few occupations as likely to experience shortages.[16]

Statewide, vacancy rates for acute-care hospitals, the only ones for which trends are available, were high, but they improved for most occupations between 1988, the year systematic surveys began, and 1992.[17] Vacancy rates declined, most notably, for radiologic technologists, from 14.8 in 1988 to 2.3 in 1992.

By 1992 the surveyed occupations, which retain high vacancy rates for the state as a whole, are physical therapist (15.8), occupational therapist (7.1), radiation therapy technologist (14), and nuclear medicine technologist (7.6). The latter two, which are relatively new, are allotted a small number of budgeted positions. With the exception of physical therapists, statewide vacancy rates tend to be lower in acute-care institutions than in all other types of hospitals. Greater Boston acute-care hospitals tend to have lower vacancy rates than the statewide average. Vacancy rates are highest for radiation therapy technologists (8.9) and physical therapists (8.4). The 1992 vacancy rate for radiologic technologists was 2.4.

Wage Levels

According to the MHA compensation survey, wage levels rose steadily from 1985 to 1992, partly in response to high vacancy rates in a number of occupations in the early 1980s.[18] As wages rose, vacancy rates declined. This MHA survey particularly highlights wage levels for therapist positions. Because these correspond to four-year-degree

levels and command higher rates of pay than many other allied health occupations, they are not indicative of wage levels for those occupations as a whole.[19] In 1992 hourly wages reached a high of $20 for radiation therapy technologist, an occupation with a vacancy rate that remained high from 1988 to 1992. The same year, radiologic technologists received an hourly rate of about $15 statewide and $17 in greater Boston, a moderate increase from 1988 levels. This occupation witnessed a steady decline in vacancy rate from 1988 to 1992. Medical lab technicians, the only assistant position surveyed, had an hourly wage of about $14. The four occupations that retained high vacancy rates from 1988 to 1992 — physical therapist, occupational therapist, radiation therapy technologist, and nuclear medicine technologist — also witnessed significant wage growth over the same period.

As will be seen below, wages for allied health therapists and technicians are substantially higher than those for Tier 2 and Tier 1 workers, thus the appeal of expanding training opportunities for workers in the latter tiers.

National Allied Health Workforce

To obtain a more detailed picture of allied health occupations, I relied on the 1992 *Current Population Survey* (CPS), which provides a national sociodemographic picture of the workforce in allied health occupations and in specific subsectors of the health services industry.[20] This information cannot be obtained from employer surveys by professional associations, from census files, which provide occupational information only, or from other regional data sources. Data reported are for jobs in four sectors: hospitals, physicians' offices, nursing homes, and all other health facilities.[21]

The CPS includes the following occupations: dietitians (97); respiratory therapists (98); occupational therapists (99); physical therapists (103); speech therapists (104); other therapists (105); clinical lab technicians (203); dental hygienists (204);[22] health record technologists and technicians (205); radiologic technicians (206); and other health technicians (208).

Unfortunately, these broad categories do not allow differentiation of workers with two-year degrees from those with four-year degrees. However, it is most likely that the therapist categories include large numbers of B.S. degree holders while the technician categories include large numbers of associates degree holders.[23]

Allied Health Professions vis-à-vis Nursing Occupations

To place allied health professions in the socioeconomic context of better-known health occupations, I compare the sociodemographic and wage characteristics of those professionals with personnel in nursing occupations, a large job category in the health sector.

Sociodemographic Profile

The *Current Population Survey* national sample represents 3,397,000 workers in the health sector in nonprofessional medical occupations. (Details for particular occupations may be sparse because of the small sample size.) The health sector includes allied health, nursing (R.N.'s and LPNs, physicians' assistants), and pharmacists. Of these, 81.9 percent are non-Hispanic whites, 8.2 percent are non-Hispanic blacks, 3.9 percent are Hispanic, and 4.1 percent are Asian. Hospitals account for 66.2 percent of

employment in the sector, nursing homes and personal care facilities for 10.3 percent, physicians' offices for 13.5 percent, and all other health facilities for 10 percent.

Allied health occupations account for almost 35 percent of nonprofessional medical employment in the health sector, amounting to 10.9 percent — 1,185,000 of 10,875,000 — of total health-sector employment in all occupations: they account for 13.1 percent of employment in hospitals, 12.3 percent in physicians' offices, 2.2 percent in nursing homes, and 13.1 percent in all other health facilities. (The hospital sector is covered in greater detail below.)

Gender Composition

As already noted in national occupational statistics, allied health occupations are primarily female although less so than nursing occupations, which are more than 94 percent female. Overall, women account for 81.9 percent of total allied health employment. The degree of female concentration varies across health subsectors, however. Women workers account for 76.1 percent of such employment in hospitals, 89.3 percent in personal care facilities, 81.4 percent in other health services, and 94.7 percent in physician's offices. Both personal care and physicians' offices employ personnel in less technical allied health occupations, which may account for the greater concentration of women in these subsectors.[24]

Racial/Ethnic Composition

Across all health subsectors, non-Hispanic white workers account for 80.7 percent of allied health employment compared with 82.5 percent of nursing employment. Non-Hispanic blacks represent 7.8 percent of employment. The Hispanic and Asian shares of employment are 5.2 percent and 4.3 percent, respectively.[25]

Earnings

Total wages and salaries in 1991 (the full year prior to the survey) for allied health workers provide an indicator of average compensation levels. Although the survey asked respondents about their wages and the industry and occupation of their longest job in 1991, it did not take account of hours worked. In hospitals, mean allied health earnings were $24,261 per year compared with $30,501 for nursing occupations (R.N's and LPNs). Allied health workers earned higher wages in hospitals than in other health subsectors. Yearly earnings of $24,261 in hospitals contrasted with mean earnings of $16,421 for allied health employees in nursing homes and personal care facilities, $17,981 in physicians' offices, and $22,622 in other health facilities.

Education

In keeping with the professional requirements of their occupations, allied health workers reported higher levels of education than the population at large. In the health sector as a whole, 18.3 percent of this workforce had a high school degree, 21.4 percent some college education, 18.4 percent an associate degree, 29.7 percent a four-year-college degree, and 9.7 percent some postgraduate education. These distributions were similar in the hospital sector, which accounted for the bulk of allied health employment.[26]

Allied Health Workers: Hospitals

Each health subsector has its own peculiar occupational structure, with hospitals the largest employer. As such, they comprise the one subsector for which the CPS yields a significant sample size.

Gender Distribution of Hospital Employees

Occupations rank by order of female preponderance as follows: health record technicians, 98.9 percent; dietitians, 97.6 percent; occupational therapists, 87.6 percent; physical therapists, 82.8 percent; clinical lab technicians, 76.9 percent; respiratory therapists, 73.5 percent; and radiologic technicians, 70 percent. Miscellaneous allied health occupations have relatively lower female concentrations: other health technicians, 66.8 percent, and other therapists, 63.9 percent.[27] These hospital-sector results are consistent with the distributions reported in the 1990 census.[28]

Racial/Ethnic Composition of Hospital Employees

Non-Hispanic whites accounted for 78.6 percent of allied health employment in hospitals; non-Hispanic blacks for 10.4 percent; Asians for 4.9 percent; and Latinos for 4.4 percent.[29]

The predominance of non-Hispanic whites varied across occupations, however. While they accounted for almost all the physical therapists and speech therapists, it must be noted that the sample sizes were too small to make their percentage estimates entirely accurate. Other racial/ethnic groups were more visible in other occupations. For example, white workers accounted for 89.8 percent of radiologic technicians; 87.7 percent of respiratory therapists; 87.6 percent of occupational therapists; 86 percent of dietitians; 76.3 percent of health record technicians; and 75 percent of clinical lab technicians.

Occupations with significant representation of non-Hispanic black workers were other health technicians, 18.2 percent; occupational therapists, 12.4 percent; clinical lab technicians, 10.6 percent; and dietitians, 9.8 percent. Hispanics were noticeably present only among health record technicians, 11.7 percent; other health technicians, 9.4 percent; radiologic technicians, 3.3 percent; and clinical lab technicians, 3 percent. Asians represented 11 percent of clinical lab technicians, the only occupation in which their sample numbers were sufficient for a percentage share to be reliable.

Yearly Earnings in Hospitals

The earnings reported here were for 1991, the year prior to the survey.[30] Hospital-sector earnings vary not only across allied health occupations; they can also diverge within occupation. Occupations like clinical lab technicians, which include both associate and B.S. degree holders, display significant heterogeneity in earnings not captured in average earnings figures. Again, the following amounts were not controlled for hours worked or years of experience.

Speech therapists had average yearly wage and salary earnings of $32,155; occupational therapists, $31,313; respiratory therapists, $28,106; and physical therapists, $26,852; all other therapists, $26,543; dietitians, $22,870; clinical lab technicians,

$24,722; radiologic technicians, $23,435; and all other technicians, $21,688. Only full-time workers had yearly earnings higher than the occupational averages for the full-time and part-time workforces combined.

Male and female yearly earnings differed somewhat within occupational groupings. For example, male respiratory therapists in the survey earned $31,813 while females earned $26,769. Male clinical lab technicians earned $28,889 while women earned $23,470. Male radiologic technicians earned $21,992 yearly while females reported $24,055. Female health record technicians had yearly earnings of $18,675, but there were not enough males in this occupation to calculate a comparative figure. It is difficult to isolate the cause of these differences in the absence of controls for hours worked, degrees held, and years of experience, although some of the variations remained among full-time workers, suggesting that hours worked were not the only cause of difference across gender. The cell count of cross tabulation of earnings by gender and education would have been too small to provide an accurate earnings average. Among full-time workers, the gap between male and female earnings in each occupation narrows because female earnings increase while male earnings remain static for the most part. This gap does not disappear, however; women's shorter work hours are partially, but not completely responsible for the differential in male and female yearly earnings. Additionally, measures of wage discrimination based on gender were difficult to estimate from these small samples.[31]

No clear pattern of earnings disparity across racial/ethnic groups emerged from the CPS national sample. Small size once again permits highlighting for only a few occupations. Among clinical lab technicians, non-Hispanic whites had yearly earnings of $23,803, below the occupation average of $24,722, as did non-Hispanic blacks at $23,125, while Asians had well-above-average earnings of $33,213. Hispanic clinical lab technicians reported below-average earnings of $23,488.

Among radiologic technicians, non-Hispanic whites earned $23,598, slightly above the average $23,435 for the occupation, while Hispanics enjoyed significantly above-average earnings of $31,340. All other health technicians had yearly earnings of $19,876, which was below the average for the category of $21,688. White Hispanic workers had above-average yearly earnings of $25,704, as did non-Hispanic blacks and Asians, $25,438 and $26,649, respectively. Like gender differences in earnings, these figures do not take into account the inequalities in hours worked or degrees held. Yearly earnings for full-time workers were higher in all occupations and for all groups, suggesting that work hours do not account for discrepancies across racial/ethnic groups.

Selected Tier 2 and Tier 1 Hospital Occupations

Tier 2 and Tier 1 hospital employees constitute the pool of potential trainees for some A.S.-degree-level allied health occupations such as radiologic technicians and clinical lab assistants.[32] For this reason, I report some characteristics of Tier 2 and Tier 1 occupations, secretary and nurse's aide, respectively. The *Current Population Survey* reported sufficient numbers for cross tabulation — 250,000 secretaries and 367,000 nurse's aides. Virtually all secretaries were female, with non-Hispanic whites accounting for 70.4 percent of them. Minority workers have a significant share in the occupation: 24.4 percent for non-Hispanic blacks and 4.0 percent for Hispanics. Secretaries' yearly earnings were substantially lower than those for allied health occupations,

averaging $15,925. Non-Hispanic white secretaries earned less on average, $15,315, than either blacks' $17,287 or Hispanics' $15,496. Most secretaries, 40.7 percent, have a high school diploma, and 34.4 percent of them had some college training, probably in secretarial courses.

Nurse's aide, a large Tier 1 occupation, is dominated by females — with 81.5 percent — but less so than secretaries. Many hospital minority workers concentrate in this occupation. Non-Hispanic whites account for 50.1 percent of employment, non-Hispanic blacks for 40.9 percent, and Hispanics for 5.7 percent. Nurse's aides' yearly earnings, $14,967, are substantially lower than those of allied health workers and somewhat lower than those of secretaries for all groups.

Allied health occupations form a middle range of positions in a sector with large numbers of low-tier and highly professional jobs and few positions between these two extremes. Particularly in hospitals, fairly high vacancy rates may provide the impetus to train the existing workforce for technician-level positions, thereby building a workforce which, once trained, will remain committed to health-sector employment. Radiologic technicians, an occupation for which some Tier 2 workers have received training, has experienced reduced vacancy rates in Massachusetts hospitals in recent years. Therefore, broadening the range of positions for which workers can obtain training will continue to improve individual worker's chances of benefiting from improved employment opportunities generated by vacancies in all allied health occupations.

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Notes

1. Jenny Laster, "Alternate Models for Providing Training for Low-level Hospital Workers to Fill Skilled Nursing and Technical Positions," master's thesis, Kennedy School of Government, Harvard University, April 11, 1989.
2. Economic Development and Industrial Corporation/Boston, *The Missing Rung: A Study of Career Opportunities for Boston Residents in Boston Hospital and Long-term facilities,* April 1992, 1; EDIC/Boston, *Who Benefits from Biomed? Real Jobs for Boston Residents,* December 1990.
3. Laster, "Alternate Models," 7.
4. Ibid.
5. Ibid.
6. Figures from the Department of Labor's *Occupational Outlook Handbook, 1990–1991,* cited in *Modern Healthcare,* May 14, 1990, 10.
7. *Massachusetts Department of Employment and Training,* Massachusetts Industry *Projections: 1991–2005,* December 1992; Massachusetts Department of Employment and Training, *Career Moves,* April 1993.
8. Michael E. Porter, Rebecca E. Wayland, and C. Jeffrey Grogan, *Toward a Shared Economic Vision for Massachusetts,* Harvard Business School, November 5, 1992.
9. These correspond to Standard Industrial Classification (SIC) codes 805, 806, 808, and 809.
10. U.S. Equal Employment Opportunity Commission (EEOC), *Job Patterns for Minorities and Women in Private Industry, 1990* (Washington, D.C.: U.S.Government Printing Office, 1990). These employment statistics cover private health-sector establish ments, including not-for-profit and para-public ones.

11. Laster, "Alternate Models."
12. Given the broad occupational groupings used for the U.S. EEOC data, I have approximated Tier 1 with all service and blue-collar workers (craft, operatives, and laborers). Craft workers are not in Tier 1, but there are so few of them in the health sector that little is achieved by excluding them from the category. Tier 2 employment, with office and clerical workers, is approximated. Tier 4, with professional and managerial workers, is approximated. In this EEOC (1990) data series, statistics refer to the Boston metropolitan area (PMSA).
13. As previously noted, I analyzed allied health occupations separately, not as part of Tier 3. Only some specific occupations are tracked by the *1990 Census EEOC File.* Additionally, the numbers reported apply to these occupations in all economic sectors, not solely the health sector. Thus, these numbers include allied health workers employed in settings such as industrial clinics in manufacturing. (U.S. Department of Commerce, Bureau of the Census, *1990 Census of Population and Housing, Equal Employment Opportunity File,* January 1993.)
14. Tables for this and the following sections are available in F. Carré, "Employment Trends in the Allied Health Professions," Center for Labor Research, University of Massachusetts Boston, May 1995. Tables 5 to 7 provide employment levels in a number of allied health professions in the United States, Massachusetts, and Boston.
15. See ibid., Tables 8 and 9, for U.S. and Massachusetts data.
16. The surveys emphasize therapist rather than technician positions: physical therapist, occupational therapist, medical technologist, nuclear medicine technologist, ultra sound technologist, and radiation therapy technologist. Additionally, over time the composition of the pool of hospitals responding to the survey may change slightly. Massachusetts Hospital Association (MHA), *Career Opportunities in Health Care,* 1989; MHA, *Health Care Personnel: Avoiding a Crisis in the 1990s,* September 1989; MHA, *Manpower Statistics Survey Results: Allied Health Professions Vacancy Rates,* February 1992 data summary, May 1992.
17. Carré, "Employment Trends," Table 11.
18. The Massachusetts Hospital Association provided survey excerpts.
19. In Massachusetts, therapist positions account for 33.2 percent of all allied health positions — the balance consists of technicians; in Boston, therapists account for 55.9 percent of allied health jobs. Nationally the share is 29.7 percent. See Carré, "Employment Trends," Tables 5–7 and 14.
20. U.S. Department of Commerce, *Current Population Survey,* March 1991.
21. Private medical professionals' offices fall into a category that combines SICs 812, 820, 821, 822, and 831; all other health facilities are in a grouping slightly different from that used by the EEOC.
22. Almost all dental hygienists are employed in dentists' offices.
23. Respiratory therapists, physical therapists, and clinical lab technicians include both four-year (B.S.) and two-year (A.S.) levels.
24. Carré, "Employment Trends," Table 15.
25. Ibid., Table 16.
26. See ibid., Table 17, for details of each subsector.
27. Ibid., Table 18. There were insufficient sample cases to give reliable estimates of the gender distribution of employment for occupational therapists and speech therapists. In other surveys these also tend to be dominated by females.
28. U.S. Department of Commerce, *Equal Employment Opportunity File, 1990.*
29. Carré, "Employment Trends," Table 19.
30. See ibid., Tables 20 and 21, for detailed results.
31. For a discussion of wage discrimination, see Francine D. Blau and Marianne A. Ferber, *The Economics of Men, Women, and Work* (Englewood Cliffs, N.J.: Prentice-Hall, 1986), and R. L. Oaxaca, "Male-Female Wage Differentials in Urban Labor Markets," *International Economic Review* 14 (1973): 693–709.
32. See Carré, "Employment Trends," Tables 22–25, for details.

Labor's Response to Hospital and Workplace Transformation

Enid Eckstein

The health care industry and the nation's hospitals are in the throes of revolutionary change. The shift to managed care resulted in fundamental changes in the delivery of care and the structure of health care, For the past ten years, hospitals have actively been merging and creating large-scale integrated delivery systems. Employers, eager to expand market share and reduce costs, are engaged in radical reorganization of the hospital and the structure of work from which no group is immune. Physicians, nurses, technicians, and housekeepers are all affected by these changes. Hospitals are reducing their personnel, shifting work outside the hospital, and reclassifying work. Employees and their unions are responding to these changes at the bargaining table, and the State House, and are actively building coalitions to advocate for quality patient care and for employment standards to secure their jobs.

A leading, nationally recognized public hospital, announces its intention to merge with a private teaching hospital. For the next two years there is a major public debate over the merits of the merger, its impact on the health care delivery system, and the effect on the more than four thousand workers at the institutions.

Hundreds of hospital workers and community residents pack a community auditorium. Weeks before, hospital trustees announced their intention to sell the hospital. Everyone is anxious. They are there to hear representatives of several major health care corporations discuss the advantages of affiliation with a specific network. Two of the contenders are for-profit national hospital corporations and the third is a major area network of hospitals.

Several dozen laundry and housekeeping workers gather in a conference room in a midsize central Massachusetts hospital. A human resources staff person nervously awaits the arrival of a hospital vice president. Within minutes, they hear about the contracting out of thirty-two jobs. Each of the affected workers has a minimum of seven years of service in what for many of them is the most secure job they have ever held. Hospital administrators tell them that they will be allowed to reapply for their jobs but that the new contractor will set different wages and benefits.

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A major for-profit hospital corporation announces its intention to purchase a medium-size suburban hospital. The corporation, with a controversial record of providing free care, seeks to gain a market foothold in the state. The company announces that it will spend $3 billion to create a network in the state. The company makes many promises to the community.

A hospital lays off forty full-time nurses. On the same day the administration posts sixty part-time nursing positions, explaining to its nurses that the hospital needs "flexibility to manage."

Such scenes are taking place across the country. Hospitals are closing, merging, or selling out to for-profit corporations. Smaller community hospitals either close or become part of larger health care networks. Major free-standing hospitals seek partners and merge. Major for-profit chains increase their control over the health care market. The merger and acquisition frenzy that shaped industry in the 1980s has come full force to health care in the 1990s. Health care procedures, once delivered within the confines of hospitals is increasingly being delivered outside the confines of the hospital.

How the industry is changing, how work is being transformed, and how both workers and unions are responding to this rapid transformation is the subject of this article. The Service Employees International Union (SEIU) Local 285 represents thousands of hospital workers who are confronted with these changes. Every day health care workers struggle and respond to the transformation of the industry. At the same time they maintain the hard-fought gains won through unionization.

The Roots of Change: Why?

The radical changes in health care are part of an ongoing transformation whose roots are in the 1960s. President Lyndon B. Johnson's Great Society expanded health care to the nation's poor and elderly with the introduction of Medicare coverage for the elderly and Medicaid coverage for the poor. By making Medicare available to the large segments of the population that had been denied care and by offering to reimburse doctors and hospitals for all their costs, including capital expansion, the federal government encouraged unprecedented growth in the number of hospitals and delivery of health care regardless of cost. The lack of a national health care plan encouraged each hospital to spend large sums of money on duplication of costly equipment. By the early 1970s, health care costs skyrocketed. National spending rose from 38 percent to 43 percent of all health care.[1]

The government, alarmed by its high medical bills, made reining in health care costs a top national priority. Beginning in 1983, the Medicare reimbursement system switched to a fixed price per disease diagnosis, designated as diagnostic related groups (DRGs) covering 468 specific diseases. Each hospital was given 468 categories into which all patients must fit. Each DRG had a preset price tag so that the hospital knew how much it would be reimbursed for each patient. In the past, hospitals billed Medicare for all patient-related costs, including depreciation, interest costs, and profits, after the facts. Under the old system, a hospital could bill Medicare for any procedure and allocate costs as long as they were directly or indirectly related to the provision of care. In contrast, under the DRG system, each hospital is paid a fixed price per patient according to the patient's diagnosis, regardless of actual cost. Under the old system, it was

difficult for hospitals to realize a profit on Medicare. The new prospective payment system provided hospital administrators with an incentive to reduce hospital costs. Since they knew the reimbursement rate up front, smart administrators could make a profit if they could cuts costs. DRGs provided an incentive to reduce hospital stays, discharge patients early, dump less desirable patients with multiple problems, and reduce the number of procedures offered to patients. Government policy shifted emphasis from expanding care and capacity to controlling costs.

Administrators used the new system to wage war on workers and existing standards. By reducing the number of patient days, hospitals began to reduce the workforce. Within a few years the number of full-time-equivalent hospital workers dropped by 145,000 from the 3.2 million of 1983, according to American Hospital Association statistics.[2] The new system managed to slow the rise in hospital costs, and admission rates dropped. While the cost-reduction drive was successful, the new cost cutting was a major boon for hospitals, which continued to expand services and invest in new construction. Nineteen eighty-four was a record year for hospital profits.

Other Pressures to Reduce Costs

At the same time, the private sector sought to reduce its escalating health care bills. Employers endeavored to reduce costs by attacking employee health care plans, building in controls by requiring preadmission testing and second opinions. Many employees moved away from traditional indemnity, fee-for-service, plans because they became too expensive. Many employers introduced a health maintenance organization as an option. Workers accustomed to unlimited choices suddenly found their health care determined and limited by costs. Employers often passed on increased costs in the form of higher employee co-pays. Many important union contract battles were fought over unionized workers being forced into co-payment for health insurance or to move from an indemnity plan to an HMO. As costs increased, employee take-home pay was reduced.

A Move to Managed Care

The drive to cut costs escalated with the rise of health maintenance organizations and others pledged to "manage" care. In a 1988 survey, 71 percent of insured Americans were in traditional fee-for-service plans and 29 percent in managed care. Seven years later those numbers were reversed: at the end of 1995, 30 percent of covered Americans were in fee-for-service plans and 70 percent in some form of managed care. Also by the end of 1995, more than 56 million Americans were enrolled in some form of health maintenance organization. An additional 70 million were in more traditional insurance plans with some features designed to manage care.

The term "managed care" refers to a wide range of organizational and payment changes that are intended to eliminate unnecessary and inappropriate care and reduce costs. Most such plans call for the formal enrollment of patients in a managed care organization. Managed care payment arrangements also vary widely, ranging from fully capitated — full risk — plans to fee-for-service — primary care case management — plans. In a fully capitated plan, the HMO receives a set fee, usually monthly, for each enrollee regardless of the type or amount of services an individual may need or use.

Shifting Power from Provider to Payer

The move to managed care represented a radical power shift in the health care payment structure. The traditional fee-for-service system placed power squarely in the hands of the health care providers. Physicians and hospitals could make money by providing as many services as possible by increasing the fees for them and keeping labor costs down. Hospitals expanded and dominated the market. Under a managed care system, power shifts from the providers to payers, employers or purchasing groups, because they negotiate a flat "per head" fee for all services provided to each person covered. Under this system, the best way for hospitals to make money is to minimize, not maximize, services and to cut costs wherever possible. The result is a new cutthroat competition based on lowering costs.

To survive financially under a payer-controlled system, hospitals have a hard time remaining independent entities for they must reduce costs and guarantee their share of the market. By networking with other hospitals, they have the potential to reduce unnecessary duplication of services, penetrate new geographic markets, and maintain their market share. Under an increasingly capitated system, physicians and hospitals make money by maximizing their patient base and providing as little service as possible to these patients at the lowest possible cost. Combined with pressure from investors to maintain high profit margins, the move to capitation has led to a new wave of corporate mergers and cost-cutting measures.

Hospitals maximize profits by reducing hospital stays and shifting work to other settings where overhead is lower. The incentive is to deliver care at the lowest rung of the delivery system. If it can be provided in an outpatient setting, insurance reimburses only at that rate. If a patient can be discharged and treated at home, insurance reimburses only at that rate. Hospital utilization rates are declining nationwide. In 1990 the average length of stay was 6.7 days per admission and in 1996 that figure was 5.6 days. Just ten years earlier it was seven days. A good case in point is the number of days a mother is hospitalized for the birth of a child. Twenty-five years ago a woman remained in a hospital for four days for a normal delivery. By the early 1990s, two days was common. In many hospitals it is now twenty-four hours after the birth of the child. In some cases discharge is eight hours after delivery.

As the length of hospital stays decreases and the number of beds declines, work is being shifted out of the hospital. As patients are discharged earlier they are increasingly sent home, where they require follow-up or outpatient care. Surgery, which several years ago required a two-night stay, is increasingly performed on an outpatient basis. This is reflected by the drastic rise in hospital outpatient visits from 80 million in 1990 to 128 million in 1995.

Hospitals are merging at an unprecedented rate and forming integrated delivery systems in which hospitals, doctors, community health centers, outpatient surgical centers, home care agencies, and other health providers form one giant entity. The hospitals claim that by joining with others they are seeking greater economies of scale and better access to capital to finance other ventures. In the last three years there have been more than one hundred mergers nationally. At the end of this consolidation phase, most major urban centers will have no more than two or three major systems in place.

The Failure of National Health Care Reform

The American public has long been demanding an overhaul of the nation's health care system. Its costs have been rising faster than anything else, accounting for 13 percent of the gross national product. During the 1992 presidential election, everyone talked about reforming the nation's health care delivery system. President Clinton, whose campaign platform promised major change in it was overrun by powerful industry lobby groups. Health care reform was "dead on arrival" when it finally made its way to Congress. Absence of a federal policy has created a vacuum that has been filled by managed care companies, insurance companies, and state legislatures eager to reduce their own health care costs. Dr. Samuel Thier, chief executive officer of Partners HealthCare System, commented that "the system is not driven by any commitment to broadening access to care. There is little incentive for managed care companies to serve the uninsured."[3]

Individual states, in the absence of national policy, have taken matters into their own hands. Numerous states, including Massachusetts, adopted their own approach to market reform. In 1991, the commonwealth deregulated much of the health care environment. The state encouraged selective contracting, which gave even more power to HMOs and insurance companies. Such contracting enables payers to negotiate discounted rates from providers in return for an expected volume of patient visits. Under this policy, a particular HMO could contract all its maternity coverage to one or two selected hospitals in a geographic area. All its patients would deliver their babies only at those hospitals. As a result, HMOs could determine which hospitals would survive and which would languish. The increased power of HMOs was evidenced by the ongoing struggle between New England Medical Center Hospital and Harvard Pilgrim when the HMO threatened to squeeze NEMCH by refusing to pay for its patients to be treated there.

At the same time, state government has encouraged hospital closings as the main hospital cost-containment strategy. Hospital closings disproportionately hurt urban poor communities. National evidence shows that urban hospital closings are likeliest in poor communities where unmet health needs are already greatest. Massachusetts has seen hospitals closed in Fitchburg, Worcester, Dorchester, and Lynn.

Pressure on Public Hospitals.

The changing market structure disproportionately squeezes public hospitals which, with public health care systems, provide an important safety net for millions of uninsured and underinsured patients. At a typical hospital, more than half the inpatient days are covered by Medicare while only 10 percent are covered by Medicaid. Most of the remainder are covered by private insurance. At a typical urban public hospital, 45 percent of patients are on Medicaid, and 20 percent pay for themselves. Self-pay includes those with no insurance, which makes it unlikely that the hospital will collect the money. This pattern is even more pronounced for outpatient visits to public hospitals, where 37 percent of visits are self-pay and 32 percent are reimbursed by Medicaid.[4] As a result, costs for treating these patients are either uncompensated or undercompensated so that public hospitals and clinics have had to rely on a variety of means to cover them. These include cost shifting to insured patients and subsidies from federal, state, and local government bodies.

Across the nation, local governments are under pressure to trim local budgets. Many local politicians believe that their governments should get out of the health care business. Local advocates for divestment are often joined by administrators who feel that public hospitals are hindered by restrictive laws that regulate their activities and restrict their ability to compete. In a further turn of the screw, government cost cutters are reducing payments to teaching institutions for the inner-city poor. Last year the University of California at Irvine lost 65 percent of its subsidies although its patients did not disappear. The hospital, giving up, began to negotiate with a for-profit chain to lease the hospital. In the last few years many local governments privatized their hospitals, cut services, or contracted out the management to a private corporation. Others are still in the process of exploring alternative options. Over the past five years virtually every Massachusetts public hospital has closed, transformed its governance structure, or been privatized. Among those affected are the following:

Hunt Hospital (Danvers): Closed
Bridgewater State Hospital: Privatized
Springfield Municipal Hospital: Sold
Worcester County Hospital: Sold
Boston City Hospital: Merged with Boston University Hospital; privatized
University of Massachusetts Medical Center (Worcester): Merged with Worcester Memorial; privatized
Hale Hospital (Haverhill): Engaged in ongoing discussions about its future

While the bottom line for individual communities may improve with divestment, the outlook for community-based health care is unclear.

Managed Care Comes to Medicaid

A major pressure on public hospitals is the shift of Medicaid to managed care. From 1981 to 1993 the number of public hospitals declined by more than 25 percent. "The mood of the country right now is that nobody wants to increase taxes," reports Ms. Burch of the Public Hospital Association. "There is a strong sentiment business does things better than government does and that spills over to people's attitudes toward public hospitals. I think people are questioning how much we need public hospitals."[4] The federal government has turned over Medicaid regulation to the states, many of which have instituted some form of managed care to administer their plan. This approach uses networks of selected providers and institutions to provide care. Private hospitals seeking to increase their patient base are eager to recruit the managed care Medicaid population. As a result, public hospitals often have a hard time maintaining their traditional historic patient base. Many are incapable of competing because their facilities are less attractive and their costs higher than those of private hospitals for a variety of reasons. When New York instituted a state program with state incentives, 300,000 Medicaid recipients joined Medicaid managed care programs. Only 8 percent joined the public health care system. Private hospitals where beds remain empty are recruiting Medicaid patients they turned away just a few years ago, forcing the public hospitals to compete with them for patients who have been their traditional base.

Across the country, local governments are working hard to dump their public hospi-

tals, seeking either to sell them off or to privatize them. These moves raise considerable serious concern over the ability to take care of the nation's uninsured poor. The California experience is instructive; hospitals subject to intense price competition and great fiscal pressure from Medicare and Medicaid reduced their uncompensated care load compared with hospitals facing less competitive pressure, according to a study of private hospitals.[5]

Merger Mania

Hospitals faced with excess capacity, losses from public programs, and managed care seek to maintain their financial stability. One strategy they have pursued is collaboration through mergers, acquisitions, and joint ventures. Merger and acquisition activity totaled $20 billion in 1994. In the first five months of 1995, U.S. health care mergers worth $13 billion had been announced in health services alone, compared with the $7 billion spent in the same 1994 period. Countrywide there have been more than one hundred hospital mergers to date. In Massachusetts the race to merge has been under way for a number of years. Its official kickoff date was 1993, when the Brigham and Women's Hospital and the Massachusetts General Hospital announced their merger and intention to form Partners HealthCare System. Three and a half years later its network includes 16,000 employees and 754 primary care doctors in eleven hospitals throughout Massachusetts and others on the drawing board. Since then numerous other hospitals have formed partnerships and their own networks for survival. Those institutions which did not rush to the altar are finding it difficult to survive as free-standing entities. Virtually every Massachusetts hospital has entertained and engaged suitors, as witness the following listing, which outlines some of the major market realignments of the past few years. Unnamed hospitals may be part of smaller regional systems or, like Quincy Hospital, may be independent. However, because these mergers occur so frequently, this inventory at the time of writing is bound to change almost daily.

Care Group
Beth Israel
Deaconess
Deaconess Waltham Weston
Deaconess Nashoba
Mount Auburn
New England Baptist
Addison Gilbert
Beverly

AtlantiCare Medical Center
Lynn

Partners HealthCare System
Massachusetts General
Brigham and Women's
Massachusetts Eye and Ear
Anna Jacques

Emerson
Lawrence Memorial
McLean
Malden
North Shore Medical Center/Salem
South Shore
Whidden
Winchester

Berkshire Health Systems
Berkshire Medical Center
Fairview
North Adams
Hillcrest

Columbia/HCA
MetroWest
Neponset Valley systems

Lifespan
New England Medical Center
Newport Hospital

The Growth of For-profit Medicine

The 1990s saw the expansion of for-profit health care systems. Companies like Columbia/HCA Healthcare Corporation, OrNda, Tenet, Quorum, and others began to dominate the scene. In the last three years, with Columbia/HCA leading a revival, more than one hundred community hospitals have been taken over by the profit-making industry. This wave of conversions has become the biggest transfer of charitable assets in history, nearly $9 billion in all.[6] In the late 1980s and the 1990s, Columbia/HCA began to build its empire, which has grown to more than 344 hospitals that treat more than 125,000 people a day.[7] Columbia earned $1.5 billion on sales of $19.9 billion in 1996.[8]

Columbia, with 285,000 workers and 1996 revenues of $230 billion, the world's largest health care corporation,[9] has come under intense government scrutiny for alleged Medicare fraud. In March 1997, the government raided its El Paso office, and in early July, FBI and other federal agents served thirty-five search warrants in seven states, launching a major investigation of potential Medicare overbilling and fraud. In one case Columbia is charged with overbilling $1.77 million.[10] In another investigation, officials are determining whether a maze of hundreds of corporate subsidiaries acquired by Columbia were used by some of its hospitals to obtain unwarranted federal reimbursement deceitfully.[11] Richard Scott, the chief operating officer, resigned as a result of the probe.

Columbia and other companies began to buy up hospitals throughout the South and Southwest in the late 1980s and 1990s. As the competition to survive grew more intense, companies with deep pockets quickly moved in. Communities with struggling hospitals became easy targets for purchase or takeover by entities like Columbia. A community that had received no tax contributions from the local nonprofit hospital was

often convinced to sell its institution or enter into a joint venture with Columbia. In turn it would receive local taxes and Columbia would establish a foundation to respond to community needs. For each of these communities the result was far from that. Within a few years of Columbia's conquest, the hospitals often reported a decrease in care of the indigent.

For-profit health care burst on the Massachusetts scene in 1995. Columbia announced its intention to purchase MetroWest, the former Leonard Morse Hospital, and Framingham Union Hospital. Despite organized opposition of the academic medical community and the public, several large public community hearings, and legislative hearings, the deal went through. In signing the document to purchase MetroWest, Columbia announced its intention to spend $3.5 billion in Massachusetts for "network acquisition." Responding to the MetroWest takeover, Rhode Island activists and legislators have won a ban on any further incursions of profit-making hospitals in their state. Current antitrust law has proved ineffective and incapable of reigning in the power of these giants. It is impossible for a small community or public hospital to compete in this market. For many hospitals the fundamental question is not whether to join a network but which network can survive.

Concern over the increase of for-profit health care stems from general concern about care delivery. When a company like Columbia diverts funds and overbills, the quality of care is apt to be affected. When the corporation announced the sale of its home care business, SEIU responded by releasing "Acute Need," a report revealing how bare-bones staffing at Columbia's largest hospital, Sunrise in Las Vegas, contributed to its inability to feed stroke patients on time; to IV dressings remaining unchanged for a week or more; to errors in delivery of IV medications and fluids increasing the risk of complications and infections; to inability to follow doctors' orders; to some patients not being bathed for three days running.[12]

Workers and Unions Respond to the Changing World

One doesn't need a crystal ball to see that shorter hospital stays, mergers, and closings have major impacts on health care workers. Those who once thought the system was stable and their jobs secure are learning about insecurity firsthand. Health care workers in every sector — hospitals, HMOs, nursing homes, and home health care — are on the front lines of an industry in change. Top-level management discuss plans and potential deals behind closed doors. Rumors fly through workplaces. Employees often learn of pending changes through the media.

Hospitals are cutting costs by reducing the number of full-time-equivalent positions. Layoffs are the most common form of cost cutting, but hospitals employ a number of other strategies.

- Reducing the number of health care jobs;
- Converting permanent full-time positions to part-time and contingent positions;
- Transferring services from inside the hospital environment to less costly community-based settings;
- Restructuring work performance and job design;

- Changing hospital governance;
- Attacking working conditions and standards;
- Challenging the union's existence.

In many areas of the country there is little union organization among health care workers. In those areas where they represent hospital workers, unions have been in the forefront of responding to these changes and to overall industry restructuring. Without a union, employees are left with little protection. As in any situation of monumental change within an industry, there are varying approaches unions and their members can employ in their fight to retain jobs. Union strategies can best be categorized in the following areas:

- Defensive fights over job retention;
- Fights over access to care and quality care;
- Control over skills and maintenance of skill levels;
- Maintenance and expansion of the union's market share and its ability to control standards within the health care environment.

Hospitals Take the Offensive

There was always an implicit social contract for hospital workers. Although a hospital job never paid a great deal, it was fairly secure. Employees worked hard and were rewarded with a paycheck, decent benefits, and a clear sense of protection. Hospitals, unlike manufacturing facilities, were not going to move overseas. Health care employees, watching other workers being laid off, believed that their jobs were safe.

Cost Cutting

With the arrival of the 1990s, the very fabric of this agreement was ripped apart. Hospital work was no longer secure! As hospitals seek to slash costs, their first target is labor. As the number of beds is reduced, patient stays are shorter, and more care is delivered outside their walls, hospitals require less staff. If patients are discharged from hospitals two days earlier than ten years previously, there are six fewer meals to prepare per patient, fewer rooms to clean, fewer tests to administer, and less laundry to process, there is less need for nurses, dietary workers, technicians, housekeepers, and people providing specialized and support systems.

Hospital jobs used to dominate the industry. In 1970, two-thirds of all health care workers were employed by hospitals. Today that population has dropped to 50 percent. The growth of hospital employment will slow in the next ten years, and hospitals' share of all health care jobs will be closer to 40 percent of the workforce. By the year 2000, experts predict, hospitals will cut 80,000 additional beds and reduce the number of inpatient staff.

Limited surveys and data demonstrate that staffs are being downsized. A 1994 survey of 1,143 hospitals and 41 health care systems conducted by Deloitte and Touche showed that 58 percent of hospitals had cut their line workers and 49 percent anticipated doing so over the next five years. The most basic form of health care force reduction is the

traditional layoff. Yet many other forms of job attrition are not reflected in these figures. Many hospitals contract out existing services like food supply, cafeteria, laundry, housekeeping, and clerical work to private profit-making corporations because administrators believe that contractors can provide them at a lower cost than their current rate. A contractor may offer jobs to the displaced workers, but at a radically reduced rate with few benefits. In recent years contracting out, which was once restricted to food service, laundry, and dietary departments, has escalated and is found at every level of hospital services. Laboratory services, direct patient care, billing, and secretarial tasks can all be contracted out. Although contractors can often offer them lower costs, hospitals can encounter problems with staff turnover and the quality of work provided. Some administrations have reinstated previously contracted-out services in their hospitals.

Another major change involves employers that eliminate a set number of full-time jobs, then simply reconfigure them as part-time arrangements that usually do not pay employee benefits. It is estimated that more than 40 percent of health care jobs are now filled by contingent workers, 10 percent contract and 29 percent part time.[13] While the increased use of contingent workers may be cost-effective by hospital standards, it can have an adverse impact on continuity of patient care.

Restructuring Jobs

Today a major focus is on reinventing or redesigning hospitals. Reengineering, which regards health care as a series of integrated processes that can be made more efficient, had formerly been limited to manufacturing but began to find its way into the hospital in the late 1980s. Health care analysts and consultants who have studied the provision of health care describe the field as a landscape of inefficiency, waste, and poor services. Chip Caldwell, CEO of West Paces Ferry Hospital in Florida, maintains that "health care, like the manufacture of cars, can be viewed as a complex production system. Transporting medical records or referring patients to specialists are all processes that can be broken down."[14] Delivery of care, the experts point out, is broken into too many fragmented tasks — housekeeping, food service, admitting, nursing, and so on. Some studies indicate that one patient admitted to a hospital is seen by more than fifty-five employees.

Over the years management experts have tried many approaches to redesigning the hospital, the most popular being patient-focused care, which involves a fundamental restructuring of work. Resources, processes, and staff are organized around patient bedside care units rather than centralized functional departments or units. The plan is based on work design and creates caregiver teams, cross-trains staff and reduces the number of classifications, makes greater use of clinical protocols to standardize care, and decentralizes most services. A 1992 survey of 311 hospitals shows that 31 percent had implemented a patient-focused care program and another 16 percent planned to do so over the following year.[15] A few basic concepts are at the core of patient-focused care.

- Caregivers are cross-trained to provide 80 to 90 percent of services patients need, including traditional bedside nursing, X-ray films, and lab work. Appropriate X-ray and lab equipment is deployed to the unit so that patients rarely leave the unit and almost never require scheduling or transportation.

- Caregivers admit their own patients and, in addition to taking charge of medical coding and billing, change linen, pass trays, and perform similar tasks.
- A protocol-driven, predefined total care plan acts as the program for the team. Nurses chart or document only unexpected or unusual changes rather than the totality of a case. Documentation time is radically reduced and medical records are totally computerized. Protocols can't rack such information as length of stay and average costs. Some physicians object because they believe that this type of structure limits their authority.
- Long-term sustainable reductions in personnel are possible.

At the heart of this effort is a program to cut labor costs, streamline care, and increase competitiveness. As one expert, Philip Lathrop, a vice president at Booz Allen, a major reengineering firm, describes it, "The huge savings enabled by the patient-focused hospital will require us to redeploy and downsize many centralized functions such as housekeeping, medical records, and routine areas of lab and radiology."[16] To do this effectively, management must combine many tasks into a few, utilizing several basic forms.

Restructured Teams

This entails using multiskilled teams to perform ancillary tasks by combining skills and tasks previously performed by a number of licensed certified and unlicensed uncertified occupations into one generic job title. Specific tasks and composition of these teams vary according to the requirements of a specific hospital, patient population, and worksite design. Kaiser Bellflower (California) Hospital restructured its staff through formation of the following teams:

Service partners. A cross-trained position that combines housekeeping, dietary, supply, transport, and nursing assistance duties. Their primary responsibility is housekeeping, but they are trained in transport, dietary fundamentals, and other comfort care skills that will enable them to assist the bedside team.

Technical partners. Cross-trained technical partners incorporate nursing assistant and lab and EKG technician duties. In addition to their duties as a traditional nurse's aide, technical partners draw blood and administer electrocardiograms.

Processing partners. These people perform unit clerk duties but are also cross-trained in nursing assistance skills to lend helping hands to the bedside team.

Licensed practical nurses. Unlike some patient-focused models, this plan retains LPNs.

Registered nurses. These nurses, who perform traditional R.N. tasks, are also cross-trained in respiratory therapy, drawing blood, and taking EKGs, all tasks accomplished at the bedside.[17]

While the extent of the move to patient-focused care is unknown, many hospitals are availing themselves of job redesign to cut labor costs and replace highly trained professionals with less skilled employees. A number of others have tried to pare costs by reducing the number of registered nurses and replacing them with less capable personnel, an approach known as de-skilling.

De-skilling

De-skilling can be defined as the process by which a job is analyzed and quantified. Those tasks which can be reassigned to a less skilled employee are so designated. De-skilling has received most attention in connection with registered nurses. Hospitals concerned with reducing R.N. costs have restructured their staffing mix and created whole new sets of job classifications with titles like patient care technicians (PCTs), nursing technicians, nursing extenders, and so forth. These jobs incorporate many tasks that were previously performed by registered nurses. Feeding, changing, dressing, and bathing patients, taking vital signs, and other bedside tasks are routinely performed by PCTs. Only a few years ago, many hospitals staffed units with 90 percent registered nurses and only 10 percent ancillary personnel. In 1995, the American Hospital Association reports, 97 percent of hospitals were using some form of nurse extender.

This is a radical shift for nurses whose labor was much in demand in the 1980s. Hospitals established staffing patterns that relied heavily on registered nurses and limited the role of licensed practical nurses. LPNs, who had previously been allowed to perform many tasks, found themselves excluded from many parts of the hospital with limits placed on what they could do. Many hospitals laid off LPNs and replaced them with R.N.'s. By the late 1980s a serious nursing shortage had been created. Management responded by radically increasing the rate of pay, benefits, and status of R.N.'s. In a large number of cities, R.N. salaries increased by 20 percent and nursing schools were suddenly flooded with applications. The late 1980s and early 1990s saw a huge increase of students in nursing programs, which shortly thereafter led to a major glut of registered nurses. Administrators of hospitals, faced with mounting costs, and especially desirous of curtailing nursing costs, examined their staffing mix and the specific tasks performed by R.N.'s.

In 1995 the Institute for Medicine issued a study stating that the "R.N. skill mix appears to be dropping in many settings from a range of 76–100 percent to a range of 52–79 percent."[18] Many workers who deliver patient care at the bedside have been cross-trained to perform these tasks, for they may previously have been housekeepers or transport workers. There is no set state requirement for certification of patient care technicians. Training and preceptor programs vary from institution to institution: one hospital may provide eighty hours of training and others several months.

Unions representing R.N.'s have been in the forefront of the fight against de-skilling. Legislation has been enacted in some states to limit the role of the PCTs, which has a major impact on the delivery of quality care. An R.N. is trained to recognize subtle differences in a patient's condition that can be important to an eventual outcome. Patient care technicians operate under the supervision of a registered nurse who may not have sufficient time or staff to monitor a PCT's work or a patient's condition. PCTs, who are not supposed to work on their own, are expected to report changes in a patient's condition. But proper assessment of change is often a matter of clinical judgment gained through education and training, not something that can be learned in a six-week training class. Nurses' unions and associations have sought to define and limit the role of PCTs through collective bargaining, state licensing boards, and state legislatures. The ever increasing use of patient care technicians and decreasing reliance on registered nurses is of great concern to the nursing profession.

The other considerable aspect of job restructuring is the multitasking approach in which several jobs are made into one by combining the duties of multiple departments under one title. As medical technology and expertise expanded during the past twenty

issues. Bargaining in the 1980s concentrated on improving wages and status for health care employees, especially nurses. The other critical thrust, a fight over staffing and quality of care, enabled local unions to make individual breakthroughs in staffing language.

As the newly created climate began to emerge, the accepted bargaining approach was limited. Administrators, as always, resisted attempts to bargain over quality of care and staffing. Hospital management tried to subvert existing union structures through the introduction of numerous total quality management (TQM) programs. Those in charge tried to convince union members that they could solve many of their concerns through TQM problem solving rather than established union procedures. Union members often problem-solved themselves out of a job. While workers may have been wooed into cooperating with management to solve hospitalwide difficulties, it soon became clear that those in power had only one goal in mind: cutting costs, especially labor costs.

Existing contract language and labor law could not anticipate managed care, hospital mergers, and for-profit conversions. Local unions recognized that the fight would take place on many fronts. They quickly developed new strategies to deal with multilocations, successor employers, multiemployers, mergers, privatization, and accretion of nonunion areas. Local union representatives, realizing that they had to become experts on mergers if they were to survive, versed themselves in all aspects of merger law and forms of governance and financing. Unions began to put forward language that would protect members.

Changes in governance put unions into the political and legislative arenas. Whether it was the Boston City Hospital/Boston University Medical Center Hospital merger, which required both City Council and state legislative approval, or the sale of MetroWest, which required the approval of the state attorney general's office, unions have had to mount a large-scale political campaign. Local unions fought to make survival or successorship of the union and its contract a term and condition of sale. Union members began to understand that meaningful job protections and security clauses were harder to win than wage increases.

The Fight for Job Security

Unions are in the forefront of the fight for job security. They seek to develop contract provisions that will minimize job loss, ensure members' future job security by giving them access to new jobs created by the employer and redesigned jobs, and protect laid-off members, which can take several forms.

- *No-layoff clauses.* Some hospital employers and unions have agreed that there will be no layoffs for current employees under the terms of the agreement. In some cases unions have won this protection as a trade-off for no wage increase or a willingness to participate in job redesign.
- *Severance pay.* Some unions have negotiated quite generous severance packages for members as a disincentive to layoff.

- *Transfer rights to other network institutions.* In the event of a merger, employees would have the right to transfer to other institutions within a network whether or not they were union ized. This could cover all facilities within a network, including extended-care facilities and home care programs.
- *Job security provisions.* 1199 New York and the League of Voluntary Hospitals in New York negotiated a model program. In the event layoffs are unavoidable, employees receive assis tance by means of training programs to learn new skills, supple mental unemployment insurance benefits, and ability to transfer to other hospitals, for example.

Bargaining over job redesign. The best approach to protecting members' jobs is to ensure that they can fill the new jobs that are being created in the hospital environment. In some cases management presents the union with newly created jobs and the union bargains about it. In other cases management and the union establish ground rules that govern negotiations over work restructuring. The Service Employees International and other unions have established general principles that include the following.

1. The union must have full participation and an equal role in the work reorganization and job design process
2. The process should be consistent with the collective bargaining agreement and should be bargained, not imposed.
3. Job security guarantees must ensure that work reorganization and job redesign do not lead to layoffs.
4. Redesign should include a commitment to training workers for the new jobs.
5. A placement process for workers who are unable to qualify for new jobs.
6. Seniority rights must be protected.
7. Members should maintain the same or greater rate of pay if moved to a restructured job.
8. Cost savings or other benefits derived from the process must be shared equitably by all participants.
9. Staffing commensurate with quality patient care must be maintained in restructuring of the workplace and jobs.
10. No contracting out or part-time jobs as a result of restructuring.
11. Protection of the unions' bargaining unit.[19]

Bargaining for Quality Care

Health care workers know firsthand that many of the changes created by managed care have undermined both their ability to deliver good care and the quality of care. As workers and consumers of health care, health care personnel are in a unique position to speak out for quality care. Unions have long supported (1) an end to gag rules and (2) patients' rights to full access to a health plan and doctors' rates. Local and international unions have been in the forefront of the fight for access to affordable quality care. Health care workers are also involved in the fight to ensure that the caregivers who deliver the services can do so in a professional, dignified manner. Health care workers bargain and fight to maintain a high-quality work environment despite all the affronts on their ability to perpetuate one. This includes proper training and certification of direct caregivers, proper staffing ratios, specific R.N. and LPN ratios to ancillary staff, and limits on the use of per diem and contingent workers to ensure ongoing continuity of care and proper health and safety protections for employees

Unions cannot win these changes by themselves. They have to join together to build broad-based community organizations and coalitions to fight for a truly patient-driven, not profit-driven, health care system. Some consumer and community coalitions have been disconnected from the concerns of health care workers, at times playing off their needs against community and consumer needs. Building coalitions that bridge community, consumer, and worker concerns is a must to mount a movement to regain control of the health care system.

Need for Policy

The lack of national policy has opened the door to corporations, for-profit med-icine, and meganetworks of health care providers. A long-term solution that restructures American medicine under a single-payer plan would provide affordable health care to all and remove the profit motive. While that may be the long-term answer for what ails the health care system, it is necessary to address a number of more immediate policy issues.

- *Merger protections.* Existing federal antitrust law has not had an impact on health care mergers. Legislation must be adopted to meet the following needs:
  - Guarantees of affordable health care to a community;
  - Full disclosure to the public of all terms and conditions of a merger;
  - Successorship protections to workers in union contracts;
  - Consumer protections;
  - Maintenance of services to the community;

- *Ban on for-profit medicine.* For-profit hospitals and HMOs are more concerned with profit making than with providing quality care. The lack of a national plan has forced states to take action into their own hands and several, like Rhode Island, have sought to limit or ban for-profit companies.

- *Quality of care protections.* There is an abundance of horror stories regarding one-day mastectomies and twenty-four-hour maternity stays. The accidental chemotherapy drug overdose of a *Boston Globe* columnist at Dana-Farber Cancer Institute points to the need for greater control over quality. Various states have passed legislation requiring minimum lengths of stay for maternity and mastectomy patients.
- *Union protections.* Health care workers are frequently the best advocates for quality care in the managed care environment. They know first-hand what is happening on a hospital floor. Doctors who have spoken out against substandard care have found themselves censured and gagged by health maintenance organizations. Doctors, many of whom cite managed care as the precipitating cause, have begun to organize in several states. Unless workers are protected by a union they cannot speak out against the abuses of managed care. Mergers and changing hospital governance should not be a green light for the industry to go after unions. As hospitals merge, larger bargaining units are created. Existing labor law has proved inadequate to cope with the changing industry. Legislation must be enacted to require the hospital industry to pay its share of retraining for the health care workers of the future.
- *Security funds.* In the 1970s and 1980s, the U.S. auto industry faced foreign competition, and hundreds of thousands of workers were laid off for long periods. The federal government, after intense lobbying, passed the Trade Readjustment Act, which provided supplemental insurance benefits and generous retraining funds for displaced workers. Similar legislation should be enacted to cover health care workers.
- The legal right to union representation should be extended to private-sector interns and residents, who are currently denied such protection. Existing labor law must reflect the changing environment.

Health care workers, who understand that managed care has brought many changes to their industry, want to know that they will be protected deceitfully as the industry continues to transform itself. They especially want to work in an environment that allows them to deliver the best possible care to their patients. Unions will fight to ensure these protections.

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From Welfare to What?

The Limitations of Low-Income Work

Lande Ajose

The premise of the welfare law enacted by Congress is that people living in poverty could vastly improve their economic status if only they were employed. The author argues that economic security for welfare recipients will not be realized simply by increasing the labor-force attachment. Home health aides comprise an occupation that could absorb many of the large pool of workers expected to join the labor market because demand for their services is high and barriers to entry are low. However, as this survey shows, the home health field offers limited promise to welfare recipients because, significantly for women rolling off welfare, it is among the increasing number of jobs in the economy that offer low wages and few benefits.

The not-so-subtle message of the welfare law enacted by Congress is that people living in poverty could vastly improve their economic status if only they were employed. The argument supporting this claim is that welfare recipients would be better off because they have would have sufficient income to meet their needs. Provisions in the Temporary Assistance for Needy Families Block Grant (TANF) to both time-limit welfare and mandate work participation assume that labor-force participation leads to self-sufficiency, if not in the short term, that is, in a welfare recipient's first exposure to the labor market, then at least in the long term, in a second or third job or substantial tenure in a first job. These provisions are even more serious in Massachusetts, where welfare reform has been under way since November 1995. Members of more than 82,000 Massachusetts households receiving welfare are expected to secure jobs within the next five years, but this is probably a conservative estimate. Since states are allowed to exempt up to 20 percent of their caseload from the time limit, the figures represent 80 percent of the Aid to Families with Dependent Children (AFDC) clients.

I believe that the promise of economic security for welfare recipients will not be realized simply by an increased labor force. The work of Kathryn Edin and Rebecca Blank provides some clues as to why this is so. Both argue that employment ignores the issue of livable wages once a welfare recipient enters the labor force. According to Edin, even though the premise of current legislation is that welfare recipients are dependent while those who are employed are self-sufficient, this, in fact, is not the case. Many public policies designed to assist welfare recipients ignore the real costs incurred

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by a recipient and her family when she gains employment. As Edin notes, "Policymakers must determine which jobs at what wage are needed to successfully bring welfare mothers and their families into the economic mainstream."[1] Blank asserts that employment will make very few recipients better off because 95 percent of AFDC recipients would earn so little that they would still be eligible for AFDC assistance.[2] It seems that, at best, jobs in many of the occupations they might be able to fill would simply move them from the ranks of the welfare dependent to the ranks of the working poor.

"The welfare problem has been defined as one of labor force participation at any level, because once a mother gets a job, policymakers assume she will move up."[3] Understanding the likelihood of escaping poverty requires examining the structure of local labor markets in which former welfare recipients might be hired. This should include a detailed analysis of potential occupations with a clear understanding of skills and training required for work, the wages and benefits such work would provide, attention to the quality of the job, and its potential for further growth through career ladders.

I examine the home health aide occupation as a potential source of employment and self-sufficiency for those coming off the welfare rolls. The home health care industry appears to hold much promise of work for them. First, its "barriers to entry" are relatively low. It specifies few formal educational requirements since neither a high school diploma nor a college degree is required. Second, to reduce costs, changing insurance schemes mandate that more people receive health care services at home rather than in institutional settings like hospitals. Third, the aging population, particularly in the baby boomer generation, suggests that there may be sustained demand for the services of home health aides, particularly through managed care systems. Finally, health care services are necessary and provided countrywide. Consequently, job opportunities exist in all areas, cities, suburbs, and rural.

Despite the home health industry's apparent promise for low-skilled workers, a central question remains: What are its prospects for moving large numbers of people off welfare and into the labor market, and more important, into self-sufficiency? My objectives are twofold. First, I attempt to document the structure and dynamics of the home health care industry with a view to understanding the opportunities for worker independence. I focus specifically on home health care in the Boston metropolitan area, which has a very strong and well-developed delivery infrastructure and provides an ideal subject for analyzing this subsector of the health care delivery system. Second, if, as I suspect, a career in home health care has limited growth potential because of its low wages and minimal benefits, what are the possibilities for advancement? The work of anthropologist Katherine Newman provides some clues regarding the promise of low-wage work for welfare recipients.

McJobs

Newman has been studying opportunities for unemployed people in Harlem to obtain minimum-wage work in the fast-food establishments that overrun the neighborhood. The fast-food industry, she charges, is one of the fastest growing service industries, providing employment "typical" of what we might expect labor-market entrants to consider.[4] Her work is particularly useful because Newman offers some insight as to how AFDC recipients might fare in the labor market compared with their job-seeking counterparts. Her research tracks the employment outcomes for 200 people who applied for minimum-wage jobs in Harlem, only half of whom were hired.

In "The Job Ghetto," Newton and coauthor Chauncy Lennon found that it is not as easy to get a low-wage job as one might think. Their study shows that there is fierce competition for unskilled jobs in Harlem. With the supply of labor largely outstripping the number of jobs, successful applicants must possess credentials far in excess of what they actually need to perform their work.[5] This "creeping credentialism" puts welfare recipients at a clear disadvantage in their competition with more credentialed, and more experienced, job seekers.[6]

In a separate study, Newman also found that U.S.-born minority applicants are less successful than immigrants in securing employment. She suggests that this may be attributable to racial stereotypes about African-American workers. Employers find immigrant workers more agreeable and less dissatisfied with their low wages, as they come from countries in which their earnings would be considered quite substantial. As a result, immigrants are preferred to American blacks.[7]

Finally, Newman's work suggests that low-wage jobs in the fast-food industry lead to very little job mobility. While there is an internal promotion pattern for workers, its steep pyramidal structure strictly limits opportunities for advancement. Furthermore, the efforts of fast-food workers (full-time employees earn about $8,840 before taxes) to seek higher wages in other industries, such as retail and other service sectors, reap meager fruit. As a result, many become trapped in low-wage jobs.[8]

While there is no strict comparison between fast food and home health care, there are some striking similarities. Employers seek credentials from certified home health aide applicants in excess of what is necessary, for example, prior job experience and strong references. To the extent that long-term welfare recipients have been out of the workforce for some time, they are at a disadvantage in comparison with other home health aides. Also, as in other areas, there is evidence suggesting that immigrants are hired in greater numbers than U.S.-born workers. Most employers indicated that the strong social networks in immigrant communities were a contributing factor, though a few mentioned a reticence to hire welfare recipients. Finally, home health aides face serious barriers to advancement, stemming mostly from the structure of the industry. These parallels suggest that home health care may offer limited opportunities for welfare recipients entering the labor market.

There are also some important differences between this study and Newman's work. On the positive side, while Newman focuses on a rather geographically defined area, which by its very nature suggests that the number of applicants per job would be high, most home health aides must travel out of their neighborhoods to secure work. This implies that competition for work would not be as fierce in home health as in fast food. On the negative side, however, there may be some logic in the creeping credentialism of home care. Unlike fast-food workers who operate in a highly supervised environment, home health aides have little daily supervision, and making a mistake is costly. Thus, a higher threshold for employment that demonstrates an aide's capacity to assume responsibility might be warranted.

The Home Health Industry

Recent figures from the Department of Economic Development estimate that the health care industry accounts for as many as 176,000 jobs in the Boston metropolitan area.[9] While overall the health care service sector is growing, certain subsectors are decreasing in size, as evidenced by continuing hospital consolidations. In 1994, for example,

3,600 hospital jobs were lost. This decline, however, was offset by an increase of 7,600 positions in private health care services, spelling good news for the home health care subsector.[10]

But there is a dark side to this brimming demand for home care. First, the changing composition of employment within institutional settings will have a disproportionate impact on low-income women of color who have traditionally relied on hospital employment as a means of entering the labor force.[11] It is anticipated that shifts in hospital staffing patterns will have a particularly deleterious effect on these workers, who comprise as much as 80 percent of the help within the industry.[12] Because the home care wage structure is substantially lower than that of institutional settings, it is unlikely that this population will create a considerable increase in competition for home care positions.[13] However, those who find themselves unemployed for longer than anticipated may encounter competition, which is most likely to result among noncertified home health aides.

The employment structure of the health care industry is an example of an enterprise with dual labor markets, a theory originally developed by Peter Doeringer and Michael Piore. It is their thesis that primary markets comprise all the features generally associated with good jobs: high wages, good working conditions, job security and stability, and opportunities for advancement. By contrast, secondary labor markets are characterized by low wages, low benefits, poor working conditions, high job turnover, and low job security.[14] The theory asserts that certain workers "are confined to the secondary market by residence, inadequate skills, poor work histories and discrimination."[15] The theory also maintains that despite the disadvantages low-income workers face as members of secondary labor markets, there is a way to break out of low-wage, dead-end jobs. In the presence of economic growth, education and training programs, and equal opportunity programs, it was postulated that there could be labor mobility between secondary and primary markets.[16] Furthermore, in the 1973 revision of the labor theory of duality, Piore asserted that the primary labor markets are further divided into upper and lower tiers, suggesting that there may be an articulated career ladder between the two.[17] Certainly the 1980s witnessed tremendous economic growth, buttressed by such federal job-training programs as the Job Training Partnership Act and the existence of affirmative action programs. Nevertheless, secondary labor markets continued to exist and, according to Bennett Harrison, are in danger of being institutionalized.[18] As the following section shows, occupations within home health care bear a remarkable resemblance to the secondary labor markets in institutional settings.

Home Care Occupations

There are two types of home care occupations, one requiring relatively skilled and the other comparably unskilled personnel. Skilled practitioners encompass nurses (R.N.'s) and various therapists, including speech, respiratory, occupational, and physical. The Home Care Association of America categorizes unskilled home care aides in four levels: Home Care Aide I, commonly referred to as a homemaker, is the least skilled and lowest paid; Home Care Aide II designates a personal care aide; Home Care Aide III is a home health aide; and Home Care Aide IV, the rarest of all, is a specialist. Table 1 outlines the responsibilities of each level. According to the Bureau of Labor Statistics, home care occupations are among the fastest growing in the nation. It has been estimated that the number of homemakers and personal care aides will increase by 119

Table 1

Unskilled Home Care Occupations

Occupation	Function	Level of Responsibility Description of Duties	Training Requirements
Home Care Aide I	Homemaker	Housekeeping and homemaking	40 hours of training
Home Care Aide II	Personal care aide	All Home Care Aides I responsibilities plus non-medically directed personal care	Home Care Aide I training with 20 additional hours
Home Care Aide III	Home health aide	All Home Care Aide II responsibilities plus some medically directed personal care	Home Care Aide II training with 15 additional hours
Home Care Aide IV	Home health specialist	All Home Care Aide III responsibilities plus developing a specialty	Home Care Aide III with additional hours (varies by specialty)

Source: Data from Massachusetts Council for Home Care Aide Services, "Home Care Aide I, II, and III Training Curriculum Outline," September 1995.

percent between 1994 and 2005 and that the number of home health aides will increase by 102 percent (from 420,000 to 848,000) for the same period.[19]

Home Care Aide IV, a new occupational level being developed by the Home Care Association of America and other industry advocates, is not yet being measured by Bureau of Labor Statistics data. The philosophy behind this level is to create home care specialties that offer these aides another rung on the career ladder and to provide better patient care. Many patients have particular illnesses for which specialists can furnish excellent treatment. Specialties are being developed in areas such as AIDS, pediatrics, Alzheimer's disease, and mental health.

Home Health Aides

The following discussion includes the results of several field interviews conducted over the course of three months with various employers of home health aides as well as trade associations for home health agencies.[20] These interviews reveal a mixed portfolio of opportunities for those in the occupation.

Home health aides (HHAs) provide daily living assistance to patients recovering from an ailment or the terminally ill who are living at home. The aides' activities include shopping, cooking and cleaning, and all aspects of general hygiene, including dental hygiene, bathing, and bedpan assistance. In addition, HHAs have several basic medical responsibilities: taking temperatures and pulses, changing simple dressings, and reminding patients to take prescribed medications. HHAs also assist in regularly moving bedridden patients to prevent bedsores and accompany ambulatory patients on trips outside the home. Considering that a substantial portion of the home care population is elderly, these activities are quite common.

The HHA range of care varies widely, depending on a patient's illness. HHAs usually follow a patient care plan prescribed by a doctor or an attending nurse. The degree of illness and the payment source dictate the amount of care a patient receives: some patients receive assistance for only a few hours a day, while others require around-the-clock attention.

Home health aides generally report to a primary nurse responsible for monitoring the medical condition of patients. As a result, a fundamental responsibility of the aide is to detect changes in a patient's condition and convey these to the nurse.[21]

HHAs fall into the general category of paraprofessionals within the health care industry. Other occupations in this grouping include nurse's assistants who work in a variety of settings, namely, nursing homes, hospitals, assisted living facilities, and home care agencies. Paraprofessional jobs are generally characterized by low wages, few benefits, minimal training, and restricted opportunities for career advancement.

Home Health Aides: Who Are They?

The employers I interviewed reported that home health aides were overwhelmingly young minority females for whom this job was often the sole source of income. The large number of women of color among the aides was probably a result of the fact that the agencies where I conducted interviews were located in the Boston metropolitan area. Industry representatives and employers outside the city suggested that home health aides in suburban and rural settings were older and "whiter" than their urban counterparts.

Surprisingly, the agencies reported that immigrants comprised a substantial portion of their workforce. Their rationale for this phenomenon varied widely, but many attributed it to the strong, informal networks within immigrant communities. Some employers maintained that immigrants were better educated, so it was relatively easy for them to become home health aides, while others claimed that it was a factor of immigrants' strong work ethic. This view implied that Americans were often unwilling to undertake the hard work necessary to become an HHA, an attitude that served as the largest barrier to employment.

Employers noted that while there were many immigrant HHAs, the countries from which they hailed differed from year to year. The latest contingent came from Africa, particularly Namibia, Uganda, Ghana, and Nigeria. However, there have also been waves of Haitians and Jamaicans from the Caribbean and Irish and various eastern Europeans. Finally, employers reported that increasing numbers of immigrant men were becoming HHAs, most of whom were working their way through school.

Employers acknowledged that HHAs generally had a limited amount of education, which coincides with the job's minimal education requirement. Although they do not need a high school diploma, HHAs must be certified. According to Penny Hollander Feldman's 1988 survey of 1,200 HHAs nationwide, their median education was twelve years, but 39 percent had not completed high school while another 40 percent had only a twelfth-grade education. Feldman also discovered that 65 percent of the HHAs were the primary caretakers in their families.

Other demographic variables from Feldman's survey confirmed my data. Feldman found that 98 percent of respondents were female, 49 percent were black, and 7 percent were classified as Hispanic. Roughly two-thirds, 65 percent, said that they were the primary wage earner in their household. The only inconsistency was in age, which in

Feldman's survey was a median of forty-five years, while most of the people I interviewed described their employees as young women. But perhaps even more important, many employers indicated that their employees were mothers whose parental skills were useful in their caretaking work.

Training and Recruitment

The minimal training requirements to become a home health aide should, theoretically, make the occupation accessible to a large number of former welfare recipients. HHAs need neither a high school nor a general equivalency diploma (GED). Instead, they must demonstrate proficiency in writing English, participate in a seventy-five-hour training program, pass a written examination, and demonstrate the requisite skills to be certified learning to keep their certification current.

A number of Boston area agencies offer training for HHAs, but the key agency for such certification is the Red Cross of Boston, whose home health aide class is the least demanding of its training programs. In addition, Red Cross training is available for health care assistant, a fourteen-week integrated education and training program, as well as nurse assistant/home health aide, a hundred-hour dual certification course. Instruction for the latter is focused on teaching students about basic care for patients in a home environment, in long-term facilities, and in hospitals. The program balances classroom and clinical experience, the first three weeks taking place in the former and the last week in the latter. Students who complete the course must register for state certification. Although the undertaking is short and rigorous, participants receive little assistance in securing jobs.

Since demand for Red Cross home health care training is very high, its programs are offered at three greater Boston sites; the Boston site offers new classes every week. Each new average class has twenty to twenty-four participants and an attrition rate of approximately 20 percent. Program staff claim that the high demand reflects the growth in the occupation, while the high turnover results from the grueling nature of the work.

Demographically, the majority of the participants in the Red Cross home health aide training program are immigrants, while roughly 30 percent are native-born Americans. Staff members believe that their backgrounds make a difference in participants' success. For example African immigrants, approximately 20 percent of trainees, tend to be better educated and do not encounter the same difficulties in taking the reading comprehension test as their Haitian counterparts, who account for about 50 percent of the program population. Similarly, the Africans have better verbal skills. While most immigrant groups tend to have extensive familial networks that allow them to balance the demands of the program against personal, usually family, commitments, this does not appear to be true of African-American and Hispanic-American trainees.

The great demand for HHA training seems, to some extent, to be stimulated by the high turnover and churning that occurs within the field, which is characteristic of much low-skill work.[22] While there is no systematic collection of information regarding turnover in the field, employers report length of tenure for aides in a range from a few months — in some instances a few weeks — to as many as fourteen years. All employers reported a consistently high turnover rate, which most attributed to the aides' constant search for marginally better wages. Comparatively low wages and minimal benefits obviously do not provide enough incentive to keep most people employed for the long term despite the intense demand for home health services.

Working Conditions in Home Care

According to employers, home health aides most often cite inadequate wages as the reason for leaving their current agency to work for another, or for leaving the industry altogether. However, my interviews suggested that factors besides wages play a large role in the decision of aides to leave their employers. The following issues offer some clues to turnover and attrition.

Hours. Scheduling is often regarded as a home health agency's most difficult task. The scheduler is responsible for matching the demands of clients to the available aides while ensuring that aides have employment for the number of hours promised to them each week — not an easy task.

Few HHAs work a traditional forty-hour week. While there are no figures to indicate how many hours per week, on average, most of them work, employers estimate that roughly 10 percent are employed full time.

The high incidence of part-time work results from the intense demand for care at two peak periods. Patients want assistance during the morning hours to help them in bathing and dressing and during the evening hours for cooking their dinner and preparing them for bed. Few patients receive around-the-clock assistance or need an aide during midday hours. This pattern leads to part-time work for most aides.

Home care aides represent just one occupation among the many that make up the new involuntary contingent workforce. According to Chris Tilly, employers within the service industry use part-time and contingent workers as a means to cut wages, keep benefits low, and maintain staffing flexibility, and the flexibility requirement drives the industry's demand for contingent and part-time workers, even though most of the aides would prefer full-time employment. Tilly claims that a contingent workforce often results in firms' decline in productivity owing to the ensuing high turnover, the low skill base of workers, and lack of job commitment.[23] Furthermore, he argues that part-time and interim work disproportionately affects those who find it difficult to form a labor-market attachment, especially women, people of color, and youths.[24]

Wages. Since the 1960s, when home care was first introduced as an alternative to institutional health care, wages for home health aides have been low. One respondent suggested that home health care is really the "negative side of charity." Prior to formal home care, aides' tasks were assumed by neighbors and friends and churches as a charitable contribution. Preparing a meal and cleaning someone's home was part of being a good neighbor and an active citizen. Once it became a component of the formal labor market, the work was undervalued and consequently underpaid.

Wages in this field are notoriously low, even in a state with a tight labor market, like Massachusetts, in which one would expect to find higher compensation. Table 2 shows the wage rate for HHAs compiled for *Home Health Line,* a trade magazine. As part of an effort to standardize wages within the industry, in the early 1980s the Massachusetts Council for Home Care Aide Services undertook a campaign to establish its minimum wage standards. The success of that effort means that today a home health aide's minimum wage should be $7.93, while the average wage should be $8.20. (These figures include employers' cost of benefits, so the aides may be earning less than these hourly amounts.) Most employers pay a dollar-per-hour bonus for weekends and time and a half for holidays. My interviewees revealed that while selected agencies offered wages above this range, many more paid less than the minimum. Wages have been frozen at

this level since 1990, and the Massachusetts Council for Home Care Aide Services, with other advocates, is lobbying to support an increase of up to 4 percent for workers earning less than $20,000 annually.

Gathering accurate wage data in this field is difficult. Data from multiple sources revealed that wages were as low as $4.75 per hour and as high as $15.04 per hour. These data vary, depending on whether an aide is certified, whether the aide is employed by a public or a private agency, the aide's years of experience, the number of years an aide has been with a particular firm. The data I present here are based on a survey conducted by the Massachusetts Department of Employment and Training.[25]

The importance of understanding these wage rates is underscored in a study by Kathryn Edin, which surveyed the incomes and expenses of 214 AFDC recipients and 165 low-wage, single, working mothers in Cambridge, Massachusetts, San Antonio,

Table 2

Average Hourly Wage for Home Care Aides, by Region

Wage Level	Pacific	Mountain	W. North Central	E. North Central	South Central	New Mid-Atlantic	South Atlantic	New England
High	$10.09	$8.48	$8.56	$7.60	$8.57	$8.28	$8.12	$10.13
Low	$8.26	$6.46	$6.67	$6.11	$6.44	$6.74	$6.79	$7.64

Source: Based on a report by Marion Merrill Dow, Managed Care Digest Series, *Institutional Digest,* 1995; original data from SMG Marketing Group Inc. (adapted from *Home Health Line* magazine).

Texas, Chicago, Illinois, and Charleston, South Carolina. She shows that an increase a working mother receives in her low-paying job is canceled out by the increase in her monthly expenditures for rent, clothing, child care, transportation costs, and so forth.[26] Edin's study showed that such expenses increased by nearly 30 percent (see Table 3). Thus, for low-wage workers in Edin's study, disposable income increased by only $5.00 per month. If we apply the wage rates for home health aides to various hourly work arrangements, we get the monthly income estimates shown in Table 4. Based on Edin's expenditure data, only full-time aides earning the highest possible entry-level pay of $9.00 per hour would be able to meet their expenses.

Benefits. Home health aides do not receive any standard benefits. Benefit packages varied widely by firm, and premiums were usually awarded only to full-time employees. Packages could include any combination of three categories of benefits: health and disability insurance, travel reimbursement, and time off. Because the packages varied tremendously, the best-case scenario offers perhaps the most candid look at how benefits are distributed. The employer in my sample who offered the most generous package first stratified his employees by the number of hours worked. Table 5 gives its details. Its implications are twofold. First, since "full-time" positions are almost always awarded to those with the most seniority, welfare mothers entering the occupation can expect to receive scant benefits. Second, with only 10 percent of the industry working what is traditionally considered a full-time schedule, very few aides would be eligible for them.

Table 3

Income and Expenses for Welfare Recipients versus Low-wage Workers

	Welfare Mothers	Low-Wage Working Mothers
Total Expenses	$876.00	$1,237.00
Total Income	$892.00	$1,258.00
Differential	$16.00	$21.00

Source: Adapted from Kathryn Edin, "The Myths of Dependence and Self-sufficiency: Women, Welfare, and Low-wage Work," Working Paper No. 67 (New Brunswick, N.J.: Center for Urban Policy, 1994),1.

There is considerable debate regarding the necessity of providing HHAs with health insurance. According to the Massachusetts Council for Home Care Services, most aides indicate that, given the choice, they would prefer cash to health insurance, for which the council cites two explanations. First, HHAs coming from welfare are generally covered by Medicaid for up to a year, so in the interim they would rather have the cash. Second, aides are covered by a spouse's insurance, which is a more likely scenario in suburban and rural areas where home health care workers' wages provide supplementary family income. An interview with one employer who services suburban communities confirmed this hypothesis.

The industry has no standards concerning reimbursement and remuneration for HHAs who travel. This is significant, since most aides see more than one client daily and many depend on public transportation. Since there is no norm covering payment for travel time and expenses, policies vary widely. The firms I interviewed ranged from contributing nothing to as much as $35 per week for travel stipends.

Table 4

Four-week Wage Estimates for Entry-level Home Health Aides, Boston Metropolitan Statistical Area

	Part-time			Full-time
Wages	20 hours/week	25 hours/week	30-hours/week	35 hours/week
$9.00 (high)	$720.00	$900.00	$1,080.00	$1,260.00
$7.93 (median)	$634.00	$793.00	$952.00	$1,110.00
$7.05 (mean)	$564.00	$705.00	$846.00	$987.00
$4.75 (low)	$380.00	$475.00	$570.00	$665.00

Source: Commonwealth of Massachusetts, Division of Employment and Training, "1996 Occupational Wage Survey," November 29, 1996, by Metropolitan Statistical Area.

Working Conditions. Working conditions contribute significantly to the low retention rates of home health aides. Since they almost always work alone, the aides are physically and emotionally isolated in their jobs.[27] This situation is compounded by the fact that HHAs are often assigned to the acutely and terminally ill in an environment that is emotionally and physically demanding. Because aides must learn to deal regularly with death and grief, their training includes a component entitled "Loss and Grief, Death and Dying."[28] When patients die, aides may often be left without a regular client for an extended period, which raises questions about the degree of job security.

Despite HHAs' low wages and minimal benefits, scholars and policymakers have suggested that there are other advantages to be reaped by most neophytes entering this workforce. One theory is that newly employed entrants in the labor market have a short tenure in their first job as they become accustomed to the norms of work and the workplace. Employers, who believe they are essentially being asked to absorb the cost of making such workers "job ready" while receiving little in return, are usually reluctant to hire them. Nevertheless, many new aides move on to a new job after a short time. The question is, What kinds of jobs might these workers be prepared for in their next assignment? In particular, what employment opportunities and career trajectory are available to a home health aide?

Table 5

Benefit Package for Home Health Aides, Best-case Scenario

	30 hours/week or more	20 hours/week or more	19 hours/week or less
$100 cash allowance toward health insurance	•		
6 paid holidays/year	•[a]	•[b]	
Free life insurance and long- and short- term disability	•		
One-week paid vacation	•		
$0.20 per hour travel reimbursement	•	•	•
Physical examination on hiring	•	•	•

[a]Based on an eight-hour day.
[b]Based on a four-hour day.

The Challenge of Advancement

The literature points to three predominant barriers to promotion for low-income workers to high-paying, higher-status jobs: (1) employee deficiencies, (2) employer deficiencies, and (3) structural hindrances.

Barriers to Promotion and Advancement

A key barrier to job advancement is employees' lack of appropriate skills and training for better jobs. These may range from a lack of such basic abilities as core competency in English, mathematics, and other subjects and inadequate language familiarity to a lack of training in a particular occupation.[29] Studies show that low-income people are often wanting in basic and occupational skills and suggest that these deficiencies serve as barriers to their continued career advancement. Generally speaking, both welfare recipients and home health aides may possess inappropriate know-how. Feldman discovered that as many as 80 percent of her sample had never been exposed to post-secondary education.[30]

The second barrier pertains to the failure of employers to promote low-income workers, for which there are several reasons. For example, there may generally be little job mobility regardless of level of earnings. One school of thought faults employers for not providing on-the-job training and other opportunities for workers to upgrade their skills. This premise has gained currency in light of theories claiming that improved technological innovations have resulted in firms' de-skilling work.[31] Finally, low-income workers' absence of job mobility may stem from employers' attitudes toward and perceptions of minimum earners. Studies have shown that many bosses practice statistical discrimination, judging potential employees on the basis of unreliable data such as race, gender, ethnicity, address, surname, and primary language. These frequently prevent managers from determining candidates' qualifications for positions.[32]

My study found that employers were partly responsible for the paucity of HHA job mobility. Many reported that their agencies offered only a few positions that paid higher wages and benefits, so it was often impossible to reward good aides because such premiums were unavailable. It is also true that there are few opportunities for improving skills. Since most HHAs work independently, they have no mentors who can teach them or expose them to new knowledge pertaining to the job.

There is no doubt that employers judge aides on the basis of irrelevant data. Some indicated that former welfare recipients immediately "raised a red flag," particularly in relation to their qualifications as potential aides. Many more said, "You can't change attitudes" and voiced the opinion that many HHAs simply had no motivation to become upwardly mobile, rendering the issue of advancement and promotion irrelevant.

Finally, the immobility of low-income workers may be structural, resulting from a firm's internal and external institutional barriers. For example, the failure to hire may reflect the paucity of career ladders developed for low-wage positions. It could also be laid at the door of labor unions for their failure to involve the workers in a union, to organize these poorly paid workers, and to display a strong union presence. Institutional barriers may also result from the level of government involvement, for example, in policies that provide disincentives for promoting workers or in providing regulation of practices that exist through nothing but the invisible hand of the free market.

There is no doubt that structural barriers pose the greatest challenge to job advancement for low-income workers. Simply put, home health aides can't move up because

there is no place for them to go. Most employers with whom I spoke indicated that there is no such thing as promotion for an HHA. Advancement is accomplished in one of four ways: (1) an HHA leaves a firm in search of better wages and, to a lesser extent, benefits; (2) after working for a number of years, an HHA is hired for a full-time position; (3) again after many years, an HHA becomes a preceptor or specialist; and (4) an HHA moves into an administrative position within a firm.[33] The last three alternatives suggest the possibility of a career ladder, but so few positions become available that these options hardly constitute a mechanism for advancement.

Efforts to develop a more articulated career progression are being thwarted by larger institutional and structural barriers. Industry advocates, who are only beginning to develop specialties as a means to HHAs' upward mobility, are finding that market acts as the largest disincentive. The federal government, the major purchaser of home care services through Medicare and Medicaid, reimburses home care agencies for providing services at a set fee. Since these rates are not adjustable for those who develop specialties, a certified agency wishing to reward employees must pay out of pocket the training costs and wage premiums for aides' additional skills. This suggests that private agencies, which can pass costs directly to their clients, might be more likely to go this route.

Managed care also makes it difficult to upgrade home health workers' skills. While managed care executives support HHAs' assignment to additional responsibilities as a less expensive alternative to employing health care professionals for such duties, they are unwilling to pay for such services. Those organizations' philosophy is to pay for immediate, not long-term care. Therefore, while demand for home health aides appears to be strong, the impact of managed care may prove that it is overstated because clients are receiving only short-term care. There may be evidence for this assertion. One respondent indicated that the length of hospital stays rose in 1996 for the first time since the early 1980s.

Overall, this analysis suggests that HHAs' slim chances of internal promotion stem from the lack of an internal labor market that could provide a career ladder for aides. Such markets have traditionally been instrumental in career advancement because they have "provided employment stability and paths within the firm along which workers could obtain training, improve job skills, and advance to higher levels of responsibility."[34] However, the analysis also indicates that the weak internal labor market is endemic to the part-time and contingent nature of home care. In sum, promotions are rare within the occupation, but this does not address the question of advancement outside it. Is it possible that employment in such low-wage jobs can have a positive effect in increasing labor-force attachment overall so that workers leave the field to take higher-wage positions? Katherine Newman, who examines labor-market opportunities in the fast-food industry, claims that there is no way to ascertain whether greater labor-force attachment results without following longitudinally those who exit the occupation.[35] The topic provides an area for further research.

Public Policy Implications and Prescriptions

This research has important implications for the success of Temporary Assistance for Needy Families, which has linked welfare to employment. Strategies have usually focused on enabling the poor to gain access to jobs, for example, through mobility programs like Gatreaux and Moving-to-Opportunity, as well as improving the skills of the poor through employment training. Most such efforts attempt to furnish unskilled

workers with appropriate qualifications for specific jobs, yet my research suggests that skills may not be enough to keep workers from becoming part of a secondary labor market in which they remain poor. The perversities of this policy are well outlined by economist Rebecca Blank, who argues that while welfare reform is intended to be a response to poverty, that is, an antipoverty measure, the policies set forth in the new legislation are in fact part and parcel of an employment strategy designed to put people to work regardless of whether it succeeds in lifting them from poverty.[36]

The foregoing analysis indicates that despite the projected increase in demand for its services, the concept of the home health aide occupation as a stable source of employment for welfare recipients should be viewed with skepticism. However, possible interventions requiring action by major institutions could be introduced to improve the labor-market situation for would-be home health workers. The first, most far-reaching response would be for the federal government to rethink the creation of a comprehensive social safety net. Such an instrument, premised on basic rights rather than on poverty status, could improve the lives of all Americans dramatically. In particular, universal health care and national child care would remove many of the barriers women leaving welfare and entering the labor markets will face and offer tremendous assistance to the working poor.

In addition to prescriptions, which help the working and nonworking poor, the government could provide antidotes to affect the home health industry. Through Medicare and Medicaid, the government has a unique degree of latitude in changing the conditions under which most HHAs work. Premium pay for home care specialists could help to build a career ladder and improve HHAs' wage rates. Other means of career ladder development require the combined efforts of government, industry, and labor, which could work together to reexamine the frame for advancement within the health delivery sector and determine how to change home health aide from a "terminal" to a "gateway" occupation. It has been proposed, for example, that there is a large gap in the occupational structure of low-income home health aides and nurse assistants, who are paid roughly $8.00 an hour, and vocational nurses, LPNs, who are paid roughly $18.00 an hour. In addition, the large divide in skills required for these occupations must be narrowed.

Finally, employers, fearing that they may have to absorb the cost of making them job-ready, are reluctant to hire welfare recipients as home health aides. This suggests a role for intermediary institutions that specialize in job preparation and offer post-placement support to their program participants. Project STRIVE furnishes a useful model in this area, offering four weeks of "boot camp" job training followed by assistance with job searches and ongoing support during the first six to twelve months of employment. Home care will be a principal focus of the organization's Boston office. The help of such groups will be necessary to facilitate the transition between welfare and work.

U.S. poverty is measured in absolute terms, that is, against an official government standard which dictates a minimum standard of living.[37] The Temporary Assistance for Needy Families legislation attempts to solve the problem of poverty by time-limiting welfare and mandating that recipients find work. However, if, as this study suggests, working people remain poor, perhaps our standard of poverty ought to be measured in relative terms, that is, against the standard of living of society as a whole.[38] Poverty in this case is an issue of increasing inequality, particularly for the working poor, helping to explain why its level has not abated despite a tremendous growth in national income.[39]

Nevertheless, the economic realities of the labor market are hard to ignore. Nationwide a growing supply of less educated workers compares with a high demand for more educated workers, and the home care industry is undoubtedly not immune from these trends. While the effects in Massachusetts are more muted because of the comparatively tight labor markets, there is every reason to believe that the overall outlook for home health aides is more positive in this state than in others.

The dual labor markets characteristic of the health care industry raise fundamental questions about issues of equity and the distribution of income within American society. Economist Paul Krugman describes the postwar boom years as a "picket fence" in which economic growth meant relatively equal growth for all subgroups within the population, but the rising tide has not lifted all the boats. These trends have changed. "Growth in the 1980s," Krugman claimed, "looked like an American staircase, with the well-off at the top step."[40] Those on the bottom step are trapped in a cycle of poverty. This offends our American ideal of equity and has ramifications for the ability of individuals to engage fully in the political, social, and economic life on which American society is based.

Ultimately, the story of employment in the health care industry is one of good jobs, bad jobs, and equity. The fact of the matter is that employment shifts in the health care industry will have a disproportionate impact on those with the least number of skills and resources and consequently the least ability to rebound from these changes. The eternal question remains: What, if anything, are we willing to do about it?

Notes

1. Kathryn Edin, "The Myths of Dependence and Self-sufficiency: Women, Welfare, and Low- Wage Work," Working Paper No. 67 (New Brunswick, N.J.: Center for Urban Policy Research, 1994) 39.
2. Rebecca Blank, "Policy Watch: Proposals for Time-Limited Welfare," *Journal of Economic Perspectives* 8, no. 4 (Fall 1994): 187.
3. Edin, "The Myths of Dependence and Self-sufficiency," 18.
4. Newman offers the following regarding the prevalence of employment within the fast-food industry: "One in 15 Americans working today found their first job at McDonald's — not including Burger King and the rest." Amazing! Katherine Newman and Chauncy Lennon, "The Job Ghetto," *American Prospect,* no. 22 (Summer 1995): 66–67.
5. Ibid., 67.
6. Ibid.
7. Katherine S. Newman, "Dead-End Jobs, A Way Out: Improving Job Mobility in the Inner City," *Brookings Review* 13, no. 4 (Fall 1995): 25, and Katherine Newman and Chauncy Lennon. "Finding Work in the Inner City: How Hard Is It Now? How Hard Will It Be for AFDC Recipients?" Working Paper #76 (New York. Russell Sage Foundation, October 1995), 9.
8. Newman, "Dead End Jobs," 24.
9. Commonwealth of Massachusetts, *Choosing to Compete: A Statewide Strategy for Job Creation and Economic Growth*, Department of Economic Development: http:// www.magnet.state.ma.us/econ/toc.htm, May 1993, Chapter 13.
10. Jerome H. Grossman and Suzie A. Blevins, "An Update on the Massachusetts Health Care Industry," conducted by the Task Force on the Heath Care Industry and Governor's Council on Economic Growth and Technology, July 1995, 32.
11. Andrés Torres, "Conference Remarks," in *The Ongoing Revolution in Health Care: What It Means for the New England Economy,* summary of Conference Proceedings, May 1994, edited by Jane Sneddon Little and Rebecca Hellerstein (Boston: Federal Reserve

Bank, May 1995), 34, and Bette Woody, *Black Women in the Workplace* (New York: Greenwood Press, 1992), 81.

12. Economic Development and Industrial Corporation, "The Missing Rung: A Study of Career Opportunities for Boston Residents in Boston Hospitals and Long Term Care Facilities" (EDIC: April 1992), and Jane Sneddon Little, "Health Care Reform in the New England Economy," in *The Ongoing Revolution in Health Care,* 12.
13. To date, the most comprehensive survey of home care labor-market conditions was conducted by Penny Hollander Feldman. Her study, "Who Cares for Them? Workers, Work Life Problems, and Reforms in the Home Care Industry," October 1988, examined the labor-market, workforce, and industry conditions for the home care industry, complete with a 1,200-person survey of home care aides in five cities. She also found that home care was being substituted for institutional care, resulting in home care workers' subsidizing the cost of care. Furthermore, she asserted that poor and elderly women were disproportionately affected by these shifts: both populations had low incomes and undesirable household situations, poor women because they were single parents and older women because they lived alone.
14. To apply these authors' typology to health care, the primary labor market has doctors and nurses in one tier and skilled technicians, for example, respiratory therapists, in another, while the secondary labor market separates office and secretarial workers from maintenance and service staff.
15. Peter B. Doeringer and Michael Piore, *Internal Labor Markets and Manpower Analysis* (Lexington, Mass.: Heath Lexington Books, 1971), 166.
16. Ibid.
17. Michael Piore, "On the Technological Foundations of Economic Dualism," Working Paper #110, Department of Economics (Cambridge: MIT, 1973).
18. Bennett Harrison, *Lean and Mean* (New York: Basic Books, 1995), 220.
19. Bureau of Labor Statistics, "Fastest Growing Occupations," Office of Employment Projections, November 1995: http://stats.bls.gov/emptab1.htm, April 2, 1996.
20. I conducted in-depth interviews with a small sample of Boston metropolitan area employers responsible for hiring and promotion decisions to gain an understanding of the overall structure of the home health care subsector and identify the barriers that prevent executives from promoting low-wage workers to higher-paying occupations. I asked employers about hiring and job advancement for home health aides. The interviews included questions regarding the types of entry-level jobs, requirements for those jobs, recruitment strategies, wages and benefits, career ladders for entry-level positions, opportunities for on-the-job training, opportunities for and barriers to promotion and advancement, and finally, demographic information regarding the makeup of the organization and that of the entry level workforce. I identified respondents through purposive and snowball sampling techniques, conducting interviews in a variety of institutional settings to better understand the areas of similarity and divergence among different types of firms. I was particularly concerned with including privately held organizations in the sample. Of a total eight in-depth interviews, the sample included three nonprofit home health agencies, three for-profit home health agencies, and two employer trade associations. I conducted all the interviews with employers and staff between August and October of 1996. As a rule of thumb, I spoke with the highest ranking individual in the firm to whom I had access, usually the president or executive director and occasionally a knowledgeable staff member. Each interview lasted sixty to ninety minutes.
21. The role of the supervising nurse depends on how an agency is reimbursed for treatment. If public dollars are used, care is given through a certified agency and the nurse is required to evaluate the patient every two weeks. If the patient is responsible for payment, care is given by a noncertified agency whose nurse conducts an orientation visit in the home and monitors and supervises the employee every three months.
22. Newman, "Dead End Jobs."
23. Chris Tilly, "Short Hours, Short Shrift: The Causes and Consequences of Part-time Employment," in *New Policies for the Part-time and Contingent Workforce*, ed. Virginia duRivage (Armonk, N.Y.: M. E. Sharpe, 1992), 15–44.
24. Ibid.

25. These data were based on surveys of 23 firms, representing 1,245 workers, in the Boston metropolitan statistical area, which were conducted between October 1995 and June 1996. Commonwealth of Massachusetts, Division of Employment and Training, "1996 Occupational Wage Survey," http://www.magnet.state.ma.us/det/lmi/wages/intrvwage.txt, November 29, 1996.
26. Edin, "The Myths of Dependence and Self-sufficiency," 15.
27. Feldman, "Who Cares for Them?" 92, found that loneliness was a significant determinant of attrition, as was the level of satisfaction with pay and benefits.
28. Massachusetts Council for Home Care Aide Services, "Home Care Aide I, II, and III Training Curriculum Outline," September 1995, 11.
29. Richard Murnane and Frank Levy, *Teaching the New Basic Skills: Principles for Educating Children to Thrive in a Changing Economy* (New York: Free Press, 1996).
30. Feldman, "Who Cares for Them?" 75.
31. Paul Osterman, "Gains from Growth? The Impact of Full Employment on Poverty in Boston," in *The Urban Underclass,* edited by Christopher Jencks and Paul E. Peterson (Washington, D.C.: Brookings Institution, 1991), 122–134.
32. Joleen Kirschenman and Kathryn Neckerman, "'We'd Love to Hire Them But . . .': The Meaning of Race for Employers," in *The Urban Underclass,* 204–217, and William Julius Wilson, *When Work Disappears: The World of the New Urban Poor* (New York: Knopf, 1996), 136–137.
33. Employers consistently believed it was highly unlikely that home health aides would become LPNs and R.N.'s. Their reasoning was that HHAs could not afford the time and expense of additional training.
34. Eileen Appelbaum, "Structural Change and the Growth of Part-time and Temporary Employment," in *New Policies for the Part-time and Contingent Workforce,* 6.
35. Newman, personal communication, 1996.
36. Blank, "Policy Watch," 192.
37. Lee Rainwater, "A Primer on American Poverty: 1949–1992," Working Paper #53 (New York: Russell Sage Foundation, May 1994).
38. Lee Rainwater, "Poverty in American Eyes," Luxembourg Income Study, CEPS/INSTEAD, October 1991.
39. Rainwater, "A Primer on American Poverty," and Paul Krugman, *Peddling Prosperity* (New York : W. W. Norton, 1994).
40. Krugman, *Peddling Prosperity,* 132.

"We Are the Roots"

The Culture of Home Health Aides

Ruth Glasser
Jeremy Brecher

This article focuses on the contributions of its workers' culture to the success of Cooperative Home Care Associates (CHCA). It examines what the home health aides bring to the culture of the company, how their contribution develops through their experience with the company, and how their heritage contributes to their CHCA work and to the company as an organization. This is one segment of a larger study that will deal with the background and history of CHCA, the vision of the founders and its implementation, the role of organizational policy, and the contribution of management philosophy to its accomplishment.

> Cooperative is an open door for a woman to become independent, to get out of the cycle of public assistance. Cooperative gives a woman an opportunity to feel important, to feel different, to feel that she is somebody. I think that when a woman enters Cooperative, it automatically changes her life.
>
> — Ana Cuevas, home health aide

Cooperative Home Care Associates (CHCA), located in the South Bronx, is an extraordinary human enterprise that has had unrivaled success in helping people usually deemed unemployable, primarily women of color on public assistance, to become competent and reliable workers. The organization has provided them with employment that is considerably more stable than most other opportunities available to them. Its quality of home health care is consistently rated at the top of New York service providers. And it has furnished one of the most widely imitated examples of a democratic, employee-owned company.

This report is based primarily on interviews with home health aides (HHAs), only modestly supplemented by interviews with other staff members, direct observations of CHCA at work, and reviews of historical company documents. The first part considers questions directly related to job performance; the second examines contributions to CHCA as an organization. Each includes background material, a discussion of what HHAs bring to the company, and a view of what they develop through their participation in CHCA.

Ruth Glasser, a public historian, specializes in oral histories of the Latino community. Jeremy Brecher, a historian, is the author of eight books on labor and social movements.

Contributions to the Work

Background: The Character of the Work

It is impossible to grasp the culture of Cooperative Home Care Associates and its contribution to the company's success without a sense of the character of the work. Home health aides perform a range of medically important procedures, including taking blood pressure, making sure patients take their medication, moving patients, bathing patients, exercising patients, observing changes in a patient's condition, and calling in further medical intervention when appropriate. The specific tasks are laid out in a treatment plan provided by a visiting nurse. In contrast to aides in a hospital, HHAs operate largely single-handedly, with occasional oversight from visiting nurses. They have to manage not only themselves but the patients and the household settings. They have to exercise judgment in unique situations. Their competence can spell the difference between life and death.

Home health aides who have engaged in nonmedical personal care and housekeeping make clear that home health care requires far more responsibility. Veteran HHA Sarah Lee (interviewed March 21, 1996), for example, attended a training program for six months and received a personal care certificate from the Department of Aging. "Taking care of elder people wasn't like this type of work. You went in their home and went shopping and did their laundry for them. Two hours with one, then another." Another HHA observed that for housecleaning, "You are just there to do the house job, no client. But in this field, you've got to deal with the client." As HHA Alma Velazquez (interviewed May 23, 1996) put it, "We get more training in things that will help to save the life of the patient. Not only medicines but also diet, many different moral and physical things that help them a lot."

HHA's role in patient care goes far beyond the specific tasks laid out in a treatment plan. Research has stressed the crucial role of human interaction and caring in the healing process; for example, people with strong families and social networks achieve greater longevity than those who lack them, and cancer patients enrolled in support groups live substantially longer than similar patients who are not. Failure to follow medical instructions, for example, neglecting to take prescribed medication or adhere to prescribed diets, is a major source of medical failure. Lifestyle changes regarding, for instance, smoking, drugs, alcohol, exercise, rest, and diet are crucial aspects of recovery and health. Yet these are all areas the present medical system finds difficult to address. HHAs who are able to contribute to these needs can make a big difference in patient comfort and recovery.

Thus the human dimension of a home health aide's work is vital. As HHA Vivian Carrión (interviewed March 13, 1996) put it, "A good aide is somebody that will care about their client, not just come in and do a job and leave." Lee noted that you sometimes hear a client talking about how good an aide is.

> She's rubbing her hands or doing her like this, touching her. You can tell by that. [To be a good aide], they need feelings. Feelings. Compassion. If you see a person that has a client and you never see her touch that client whatsoever, then you know she's not going to make a good aide, that she's in it because she has to be, that's work for her, but if you see a patient with a client, and she's forever touching that client, and she's forever talking to that client, then you know she's a good aide, and you know

she has compassion. But if you've got one that doesn't show compassion, they're not going to make a good aide.

In Lee's view, many of the things that make a good aide are learned in childhood.

> First, there's compassion. The ability to accept things that you can't do anything about. Comfort, try to comfort people, and most of all, be a friend to them. Be a real good friend to them, because most of them need it. If you get a elder person, not even a elder person, anybody, and you touch that person, especially an AIDS patient, or you even give them a hug, or squeeze the hands or something like that, and show them that you are not scornful of them, that makes their day. You got some aides, people out here think, if you talk to them, or you touch them, then they going to get AIDS.

Communication is critical to an HHA's work, as one aide explained:

> You have to have some communication with them. They're going to tell you about their family, they're going to tell you about their medication. You got all day to listen to them. You can't just go there and do what [the visiting nurses] tell you to do, bed, bath, sit in the tub or take a shower, fix their food, and go to the laundry. It's always something else in between that they are going to talk about. Even though you give them breakfast, they going to set down and start talking, they going to be telling you about their family so you got to listen to it and learn how to keep it confidential.

Many home health aides who have held other jobs comment on the difficulty of the work. We have come to agree heartily with Lee: "This is not no easy work. This is no easy work whatsoever." Beyond the demands of the work itself is the problem of dealing with extremely difficult patients and families. "They think you're their maid. They want to control you, they want you to jump when they snap their fingers, give you an order, they want you to do it right then, they act more like they doing you a favor than you are helping them."

Carrión gave an example of a patient so difficult that few HHAs were willing to work for him.

> We had this patient — as a matter of fact the company doesn't have him anymore because no aides wanted to go to his house. The aides kept leaving him and leaving him and leaving him. Then when it was my turn, my coordinator told me, Vivian, he's like this and like this and like this. And, oh my God, he made everybody's life miserable. He cursed all those aides out, I heard him curse at those aides. And the company got rid of him, because they didn't have no one to go there when the last aide quit. The company talked to him and his relatives, who were really nice, but they couldn't get through to him. You try your best, he always used to find something wrong.

HHA Traditions and Caring Experiences

In recruitment and hiring, Cooperative Home Care Associates places strong emphasis on people with experience caring for others. While in some cases this includes work experience, it more often means caring for ill, elderly, and disabled family and community members. Interviews with them indicate that HHAs are frequently people who have

dedicated substantial portions of their lives to such caring. What also emerges is how often this represents the continuation of a tradition of caring handed down, usually from older female relatives, and how deeply the caring role is embedded in most HHAs' role and identity.

Carrión's parents were born and married in Patillas, Puerto Rico, then came to Manhattan and the Bronx.

> I have gone with my mother when my mother used to take care of people in the neighborhood. My mother was always a community volunteer. She helped, especially the ones that didn't have anybody to help them. I think that's why I got interested in this job. She used to help a lot of people that were homebound. And when I was growing up, as far as I know, there was nothing like home attendant or stuff like that. A lot of people who were homebound relied on church people to come and help them. She did it on her own, but she also did it through the church.

Her mother took her on some of her home visits.

> The first time I got real scared. I think I was about ten or eleven. And she was cleaning this lady with the ostomy bag, and I thought it was so gross. I got nauseous. But then my mother tried to explain to me: "You know, this lady has this disease and she couldn't pass her stools the normal way, and the only way the doctor could save her life or she will die was to do the operation." She didn't go into big words or anything, she just told me, "Don't worry. As you get older, you'll understand." And she said, "People are still the same, even though they look different." And she was some special lady. And she used to tell us, "Even though something might look a little strange to you, people deep down inside they're the same." That's why when I'm having a problem I think about her or my granddaughter and it seems to give me a lift.

When she was about sixteen, Carrión helped her mother to take care of a grandmother who had cancer who had also undergone an ostomy.

> The feeling came back. I said, "Oh my God, this looks nasty." But this is my grandmother, and I loved her. So when my mother used to go over and take care of her, I used to go and help her. And one time my mother couldn't go so she sent me. And I did it by myself. I changed her, I washed her. I didn't feel like the first time, like ugh. I didn't have any problem after that.

Carrión believes that her mother had a deep impact on her ability to do HHA work. "I like people in general. Like my mother said, everybody deep down inside, we're all the same, even though we might look different, so the way she brought us up, I guess that helps a lot."

Florinda Pimentel (interviewed June 21, 1996), who grew up in Santo Domingo, Dominican Republic, also had an ethic of caring ingrained in her from an early age. "There was an elderly couple that since I was nine years old I had to care for them, because my mother made me. I had to go for two hours each afternoon to prepare their lunch, to clean the house a bit, wash and organize their clothes."

Betty Cooper (interviewed May 23, 1996) was raised in New York by a foster mother who took in many children on both a short- and a long-term basis. When there were bake sales, Girl Scout events, and other community activities, her foster mother was always

involved. "She was always a part of something in the community; she loved it because it involved children." Her mother encouraged her to participate; when she resisted, her mother said, "Go and see what you can learn, even if you don't like the leader."

Cooper wanted to be a nurse, an aspiration she traces to her mother's concerns. "I remember Mom saying that there are so many sick people that nobody cares anything about, and when you go to the hospitals and things it looks like sometimes they don't have the time to help you. Sometimes just to have somebody to talk to is good." She traces her ability to be a good HHA to her mother's attitudes.

> [She] always had an answer for something. And it was never harsh or embarrassment or anything like that. It was always, you can be as good as you want to be, and you can treat the next person the same way. A lot of times I have taken that attitude into some of these homes. Because you find some of the clients, they're angry because they're sick, they're angry because they're shut in, and they can't do the things they used to do. They can't walk, or they can't take care of themselves, and I don't know, somehow I just got that extra something. I say, Mom would have done so and so. And most of the time I come out on top. Everybody that I've really, really worked with, most asked for me to come back.

On many occasions, others recognized these women as natural caregivers. Sarah Lee, who came from a North Carolina family, recalled:

> When my father got sick, my sisters and I and my brother, my aunts, and others tipped in to help him out. He stayed sick for about a year and a half, and I took a leave of absence and we had to take turns in the hospital because they didn't have that many nurses helping him out, helping my mother out so it wouldn't be too much on her. And when the doctor got ready to tell us what was wrong with him, out of all my brothers and sisters he picked me to tell what was wrong and left it up to me to tell my mother and the rest of the family what was wrong with my father. And then I saw other people in the hospital that weren't getting as much care as my father because he had his family around and they didn't have anyone except the nurses. [The hospital] was doing the best they could but they was short. So that's how I became a home health aide in the first place, because of what I was doing for my father, and what I saw in the hospital: that there were people there who wasn't getting the care they was supposed to be getting because of the shortage of nurses. So I said, there's other people in this world that's not getting the care they need.

Since many of the HHAs grew up in tight-knit neighborhoods or rural towns, they modeled their idea of caregiving after their own childhood experiences of family and community. Lee commented:

> You see some of the elder people out here just can't make it, and they don't have anybody helping them. Sometimes the family's not that close, so they don't see them. And we, the home health aide, are the only people they come in contact with that they call their friend, that they talk to, telling you their personal problems. Sometimes it gets too much for you, it weighs heavy. Because they tell you, don't get involved, but how can you not get involved with a client? You see they don't have anyone but you. They talk to you, they tell you everything.

HHAs also bring a more mundane form of training in skills and self-discipline to the job. As one aide put it, "If Mama didn't make me stay in the house to cook, to iron or to

wash, and do things to clean the house or whatever, I don't think that I would be able to do this." Bibi Yusuf (interviewed March 7, 1996) described her difficulty getting to her first case by public transportation and how nervous she was when she arrived. "And then I started doing the work, fixing [the client's] breakfast, helping her with this, making the bed, tidying here. Those are things I'm accustomed to doing every day, so I didn't see it like something huge."

Dealing with Difficult People and Family Situations

When asked what is the most difficult aspect of the job, many home health aides reply that it is dealing with difficult patients and family members. But as observers, we have been struck by the frequency with which both HHAs and other staff members at Cooperative Home Care Associates address these difficulties as problems to be solved rather than as simply something to complain about. One HHA describes how she calms both herself and a visually impaired hypertensive diabetic patient by drawing on religious faith, counting to reduce agonistic arousal, calming talk, helpful activity, sharing her own experience, and empathic listening.

> In this field working, sometimes you have to swallow a lot. And sometimes you have to say, "Lord, give me strength" and count one to ten. Some of your clients is not all p's and q's; some of them'll get on your nerves. I'll give you an example. This morning I got to work at a quarter to nine. When I rang the doorbell, the first thing she met me: "I can't find my syringe!" She was all up in a rage. I said, "Lord, give me strength." I tried to talk to her. I said, "Calm down." Because she's the type, she's diabetic, and she's hypertension, and she gets upset just like that. The least little anything.
>
> We are supposed to go to the laundry today. "Oh I ain't going nowhere, I can't find my syringe." I don't know what she want to find the syringe for, because she wasn't using those syringes, but in the back of her mind, somebody done moved her syringe. So I told her, "Calm down, I'll go and look for your syringe." So I went in there and they were up in the closet. She can't see, her vision is bad, so she didn't see the syringes. When I came back she said, "Oh, where did you find them?" I said, "Up in the closet." "Well, I looked up in the closet, I didn't see them." What can you do, you have those people like that. Sometimes they get on your nerves really bad, but you just have to cope with it. You want to work, you have to do it.
>
> With this lady being hypertension, I know I have a certain way I've got to handle her. I have to talk to her, I have to tell her in my terms that's how I am, because I am also hypertension. Sometimes people come by, knock on the door. Right away she goes off, "Why they knocking on my door?" I say, "Don't be like that." And in a few minutes, if you talk to her, she calms down nicely. She has a lot of problems, so I guess I'm the only one that she could really give off on. Because I'm there eight hours, automatic she going to talk to me about this and she going to talk to me about that.

Yusuf said that with clients who are not feeling well and who are occasionally nasty,

> I never thought of saying anything. I would just keep quiet and try to do something else, and I would come back to them and think, Okay she's not feeling well, let me go and make her a cup of tea or find something to do not to make her more upset.
>
> One client I remember specifically. Even though she was very ill and I was trying my utmost best to help her with her food and personal care, she was more

> concerned with whether the floor was mopped every day or the bathroom was cleaned every day. So that's like taking away from herself, and I know the nurse specifically said to focus more on the client because she was very ill.

At the nurse's suggestion, Yusuf tried to read to the client, but she got angry, saying she could read by herself.

> I was trying to figure out how do I try to please my client. This is what I was told to do but she was more interested in the other thing [the cleaning]. I was doing it, but she wanted it done more often even though it didn't need to be done. That was just something I had to battle for myself and think, Okay, well, I just have to try to make her comfortable, make her happy. If that's what she wants, like if she wants the fridge defrosted every week, I just have to do it. Because I don't want to aggravate her. This is what made her happy.

At times patients' behavior can be truly extreme. Trinidad-born Annette Dance (interviewed May 17, 1996) said, "In this job you meet some weird people, some weird things, some weird habits, some sexual things that people put on you. Guys come after you, they'll offer you money to go to bed with them. Because he's a diabetic and he can't get this up — crazy stuff."

She arrived to take on one new patient only to have him ask the nurse if her crotch was wet. "When I see how he reacts, I say, 'Oh, I must be in for it.'" For the first couple of days he was all right. "Next thing I know I go there one morning — you're riding on the bus for an hour and a half to get to work — and I get there and he has no clothes on." She coped.

> I told him, "You know what I'm going to do. I'm going to take a walk, you get your head together, when I come back, another ten minutes, you could put your clothes on." Then next time I go back he's hanging out. I saw it was going to be a constant problem. So what I tell him, I point and say, "That little piece of thing you have hanging out, you should be ashamed, you should really close that stuff up." Embarrass him into putting on clothes.

Bigotry is one of the most difficult conditions to handle. Lee recounted how she has "come in contact with prejudice" on the job. "I had one case, the lady had gone to the bank, and the lady she was dealing with was black. When she returned home, the patient didn't know that I was in the kitchen. She was in the bedroom and she was telling one of her neighbors, 'I was dealing with this niggerish woman and I didn't even know it.' So when I came out of the kitchen, she got this strange look on her face. She asked me, 'Did you hear what I said?' I said, 'No, why, what you say?'"

Lee says she learned to control herself in this way in other jobs before working at Cooperative Home Care Associates. " I didn't do it in just one day, or not even two months. It took a couple of years or more for me to learn how to control. But when you're in someone's house and you're doing a job, you have to learn how to control. And I used to call my coordinator a lot, and I would yell at her to get it off my system. But she understood. I would tell her what had happened and why I did what I did."

She says it was hard for her to learn, because she is outspoken by nature. "On the job, you're there to do that job, so you do that job, and you have to learn how to bite your tongue, count to ten, which I have done a whole lot, because like I said, I'm outspoken,

but when you're working, you have to bite your tongue a lot and you have to count, and you have to say the Lord's Prayer a whole lot, because some are very prejudiced."

Florinda Pimentel experienced prejudice that turned into abuse. She was sent to the house of a Puerto Rican woman who declared that she didn't like Dominicans, saying, "If you're going to work here, you're going to do what I tell you." Florinda replied, "Fine, as long as it's within my job description." But the woman continued to insult her, gave her unreasonably heavy housework, threw her breakfast against the wall, and refused to let Florinda sit down to eat her lunch. With great effort, Florinda controlled herself, but told her coordinator that she had to leave the case.

Family members can be as difficult as patients, and handling them skillfully can be important for good patient care. Vivian Carrión said,

> You have families that will try to help, to share the responsibility that we have. But there are some of them that just want to come in and take over. [That] is fine; as long as they're doing something right for the patient, I really don't care. But sometimes they want to come in and take over and really hurt the client instead of helping them. For example, if I have a diabetic and they bring them a piece of pie, a piece of cake, I say, "Maybe you could just have a thin slice." Because you don't want to say, "No, you can't eat that." And they usually go along with that. It depends upon how you say it. If you're going to be aggressive, they're just going to push you out of the way. "No, this is my mother." And they'll just give it to her.

Annette Dance remembers a long-term case with a very obese patient who had to use a walker. She had a pacemaker, had suffered a stroke, and didn't talk for the last three years of her life. It was a "crazy family to work for. Too much people and noise." She had to fight to save food for her patient from the rest of the family. "I could watch her and figure out what was going on. I would go away on vacation and come back and immediately see if something was wrong and call the doctor." Some family members would smoke and curse in the house, and sometimes the home health aide threw them out of it, because only the patient was supposed to be living there. (The patient's daughter and son would back her up, though other family members didn't care.) Dance observes that she had to control the family in order to get the patient what she needed.

Sometimes the HHA's interventions help other family members as well as the patient. Betty Cooper had a client whose son had mental problems. She could see them coming. He was in and out of the hospital. "Mom means well, but he's old enough to make his own decisions and she doesn't let him do that." The aide called and talked to him. He was very happy to hear from her and grateful that she was helping his mom. "He said he tried to keep the stove and bathroom the way she did, and the windows open for fresh air." Cooper asked him please to take his medication and stay in the outpatient clinic.

Initial conflict can be followed by great closeness between aide and patient, so the patient's death can be a blow to the aide. Dominican-born Miguelina Sosa (interviewed February 23, 1996) remembers that she eventually became good friends with a difficult patient.

> There was a ninety-two-year-old patient, a Puerto Rican woman. She lived alone, she had two sons and a granddaughter. One of the sons came almost daily to the house and they had a lot of arguments, they parted with arguments. I would say to her, "Do you want a cup of tea or a glass of water?" And she answered me, "I haven't asked you for water," very rudely. So I would disappear, I'd go into the

kitchen or the bathroom, leave her alone so that she would calm down.

Eventually, Sosa's patience won the patient over, and they spent many interesting hours talking about the woman's memories of growing up. When the patient died, Sosa felt a great loss. At the same time, the woman's friends acknowledged the aide's special role in her life: "When I arrived at the funeral home, there were the people from the church, the neighbors and all that. The people came to me and said, "What a shame, your little old lady died."

Problem Solving and Judgment

Good home care cannot be provided by rote. Every patient and every situation is different, requiring problem solving and judgment. Carrión said,

> It's like dealing with a book of regulations; sometimes when you're dealing with people you just can't go by the book. You're not going to do something that's going to get you in trouble, but sometimes the rules have to be bent a little bit. We're allowed to do certain household tasks, but we're not allowed to do certain things. Like, for example, we're not allowed to get up on ladders and change curtains. But sometimes you have clients who don't have a relative or somebody to come over and do it, and if you think you're capable of doing it, you do it. I also have a client who sometimes can't get her own insulin. Now [if I do that for her] I will lose my job. I wouldn't do it. But I will call the nurse and tell her, "Listen, she's having problems with her other arm and she's having difficulty giving her insulin, she keeps squirting it out." And the nurse will come.
>
> You have to use your judgment, what you think you could do without getting yourself in trouble, and without hurting anybody else, and without hurting the client, of course. You have to have a good sense of judgment because that's the only way that you could really help people that really need help. You just can't go in and say, "Well, I'm going to do what's on my regulations." You've got to go into people's homes and first you've got to observe, of course, and then you have to decide how you're going to handle this person. You just don't go and handle everything the same. Some people might be more sensitive than others. Some people might be more aggressive than others. You have to go with an open mind when you go into people's homes. You have to remember you're a stranger going into their house and they don't trust you just as much as you don't know about them.

Dance similarly emphasizes the need for flexibility in dealing both with patients and with institutions. "A lot of times I make a lot of noise, but then there are times you have to be soft, you have to know when to get that point across, maybe in a softer tone, but direct. You have to know [how] to manipulate your patients or the institution you're into."

Because much of the work is performed in dangerous areas, good judgment — "street smarts" — is often required to do it safely. Carrión stated, "I was born and raised here, so I try to be as careful as possible and look around. I went into this building one time and I'm telling you, all I could see is the dirty condoms in the hallway." There were men who appeared to have been drunk or on drugs. "I was afraid, because they used to hang out in the hallway during the day. I told my coordinator and she just told me to be careful. The men said hello; she said hello, walked right by, and went upstairs.

> One thing about this company, if you go into somebody's house or building and you

> don't feel safe going in, all you have to do is call. You're not forced to go in. But it has never come to that point where I'm afraid to go in. I am afraid, but I'll go in. But if I ever see that I'm in danger, I will run out. And the company doesn't hold that against you. I would call from the nearest phone in the street. I've got to think about my safety too.

Creative problem solving is often essential to administering effective treatment. One home health aide describes how she deals with a hypertensive patient's demands for more salt in her food.

> She's on me about salt. Now I'm not a big salt user, I don't use salt. But she want to use salt and she don't need salt because she hypertension. I say you don't need this and that. But you know what I found out I can do? She says, "Oh, you fixed me some grits, put me some salt in it." I get the salt shaker and shake it like I'm shaking salt in it. I ain't shaking nothing in it. And I say, "Oh, I don't think I put enough of salt." You put a little bit in there. So there's always a way to get around them, even though they get on your nerves sometimes.

Her skills for coping with this situation come from her own experience both in her life and on the job. "I learned that because I'm hypertension myself. All the things that I went through, the doctor told me you don't need to go through. You've got to learn how to control yourself. I have to be in control to help control her. Because if I'm all whacked out, she's going to be all whacked out too. Sometimes to get her mind off things I go out and buy her a little box of Equal. You learn things just as you go."

Many home health aides appreciate the fact that, in contrast with many other situations, in these jobs they can utilize their intelligence. Pimentel commented: "I like the complicated cases, because with them one doesn't get bored. You have a lot of hours and you're always busy."

She enjoyed her work with a patient who'd had a stroke and couldn't speak, so the HHA learned to read her nonverbal signals. "When I brought her what she had asked for, it was a joy, because I saw in her face that she knew I understood her."

Stress-management Skills

Dealing effectively with the job requires aides to deal effectively with their own stress. Annette Dance described some of the techniques she has used.

> A lot of times count to ten, walk away, drink water, a lot of praying. Or put things back in their perspective. I'm in this person's home, and she does not feel well, she doesn't want to be bothered. Would you like to be bothered if you don't feel well, if you had this disease? For me, trading places with the person has helped me a lot. Sometimes I would go totally berserk on the patient and make something funny. Then I'll have them laughing because I'll try to say something funny or do something funny. Right now I have a patient with those big old walking shoes, orthopedic shoes. I say, "Let's get your blue suede shoes." To get her to put her shoes on, because she doesn't want to wear them.

Religion and spirituality play a significant role in dealing with stress.

> The stress of going to work in different neighborhoods, going in people houses —

you go in people houses, different atmosphere, people have black candles, green candles. For me, I open doors, I walk spiritually. I may laugh and make a lot of jokes and fun around, but I have to be very spiritual to like this kind of job. To go into people homes, people who are so sick and who envy you because they're sick, [or] they're in a state of denial. It's a lot, a lot of stress. [Spirituality] helps me to walk without fear. Helps me [if] I see you have things that to me don't look kosher in your house. Helps me [to believe that] whatever you do is not going to harm me. That's strong spirituality. Going into buildings that you see people . . .

I've gotten jammed up a couple of times in elevators . . . Just walking the streets alone in different neighborhoods . . . You have to ask God to take you there, bring you back home. I don't bring it out much in my meetings, I bend my head, people might think I'm bending my head just thinking, most of the time I'm praying, asking God for us to open our minds and heart in what we're doing here, is this the right thing.

Sarah Lee described how she deals with stress and some of the tolls it takes.

Take it out on my family, my husband especially! I come in sometimes and he would say something to me and I would blow up at him and then later on I explain to him that I had something on my mind. I wouldn't go in detail because [the patient] told me in confidence. I just tell him that I had a bad day. Or, I explode at Alice [my coordinator]. Sometimes I come in, I play gospel music. I used to take a drink but I don't drink anymore because I'm a hypertension. Sometimes I come, get by myself, and I just cry. And that's it. Or take me a nice hot bubble bath, that'll relieve some of the stress. I pray and listen to gospel music. And cry a lot.

Carrión had a quadriplegic patient who was so difficult that few aides were willing to work for him.

I used to turn off my husband a lot, completely shut him out mentally, so I started to do that with [this patient]. I did what I had to do. If he needed to be changed, if he needed to be suctioned, whatever, I did it. If anything had to be cleaned, I cleaned it. Then I would go into the living room. He was always in his bed, and that was his choice. I used to go to the living room, either read a book, read my newspaper, or watch TV. And I used to just block him out. I guess he wanted me to fight back, like the other aides, and I didn't fight back. So as the time went by, it was more easy. The difficult days were less.

Values

Because the low-paying home health care work is highly demanding, most successful aides have to find intrinsic motivations to do it. Carrión said, "If you don't care about people, you can't do this job." Lee would tell new HHAs,

You can expect rewards, personal rewards. No one is going to walk up to you and say, "I reward you," but with your own feelings you know you helped the old lady today or old man, [help] that they would not have got if you weren't there. That you went in and you did the best job you could for them, and they say thank you, that's rewarding in itself. You not going to get it from everybody, so don't look for it from everybody. And it's a very difficult job, you have to want to do this. And don't think you're going to come in and make a whole lot of money because you not. Yes you

> going to get paid, but you not going to get rich off it, except by knowing the fact that you helped somebody, somebody who couldn't help themselves. And one day, if we all live to see it and get old, somebody going to turn around and do the same for us. That's what I'd tell them.

She sees this attitude as rooted in her family's values. "The home training, the talks and things my father and mother used to tell us. What goes around comes around. You mistreat someone, someone going to mistreat you. You be compassionate to someone, someone going to be compassionate to you." Bibi Yusuf, who comes from a conservative Muslim family, expressed it this way.

> When I started doing this job, my family didn't understand why I wanted to do it or how I managed to do it, where I had to like feed someone, clean someone, because I never had this experience before in my life. But I said that when I went home at the end of the day I feel like I did a good job, I earned my money, I made a difference in the world, and somebody depended on me. And the way I would talk with pride about my job, and about my clients, it put a whole different feeling, like they have a new respect for this job, they saw it differently. "Wow, you do all of that?" And to someone else it's like a little but, hey, not everybody could do that, because you've got to go in there and take care of someone and it's not an easy job. My sister said to me flat, "I can't do that, I don't have the patience for that."
>
> When I first did it, I said to myself, If I don't like it and I think I'm not doing a good job, I'm going to switch. Many people said to me, "Why don't you go to school, Why don't you become a bank teller?" I said, "No, my job may not be a lot but I love my job, I enjoy my job." When I didn't have a job, I would be calling [my coordinator] every day. I didn't care if it's a replacement, I had to take two buses — I wanted to go because I enjoy it, and it made me feel good.
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> I was right in the job, especially religiously, in my religion. They don't even think women should go out and work out there, but with this kind of work . . . I always wanted to be a teacher or a nurse. And I find that I'm getting satisfaction from my job. The paycheck was important. I had to pay my bills, but at the same time I enjoyed what I was doing. I felt like I made a difference.

Commitment to the job can lead workers to do it better. Annette Dance, working with a patient who had fluid in her lungs and broken ribs, asked the doctor if she should make baby food. The doctor said it would be a lot of work, but it would be better, so she did. "The better care I take of my patient, the longer she's going to live, I'm going to have a job, she's going to be home. Because of your misfortune in life, I have a job. I put food on my table because of your misfortune, so I should be able to give a little care and a little more, a little extra."

Commitment to the success of the company provides a related motivation. A difficult patient can provoke the following conversation: "You listen to the neighbor when you're doing the laundry: 'Oh, you're another one already, again?' You'll hear stuff like that and you'll find out later on [that the patient] probably had three different agencies there with different aides changing like every two days or every week. You want to work, and you want to make this company work, [so] you find a way to cope."

Individual Skills and Talents

Many home health aides bring particular skills, talents, and experiences to their work. Vivian Carrión grew up bilingual in a multicultural neighborhood. "I grew up in a

mixed area. You grew up with blacks, you grew up with whites, and you grew up with your own nationality. Speaking both languages, I help a lot of the girls that don't understand English." Now, accompanying them on their visits to doctors, she acts as an interpreter for non-English-speaking patients. "A lot of these patients keep their illness a secret from their families. They don't want their families to worry too much about them. The family might know what's going on but they don't want to go into details. A lot of them do have some family member or friend that could go with them on their appointment, but they choose to have the aide who speaks both languages.

Betty Cooper brings special knowledge and compassion regarding AIDS, which she shares with other HHAs, out of her own personal tragedy. Her son was diagnosed HIV positive in 1987. When he told her, she didn't know very much about the disease or its seriousness. So she said to him, "'What we're going to do, we're going to deal with this as a family. So you're HIV positive, so you go to the clinic and put yourself there so you can get medications and then start treatment, all right?' And he said, 'Mommy, I'm not going to lose my family?' And I said, 'No, that would never happen, we will always be here.' For several months I shut it out, because if you really think about it, it's devastating." Her son had to have home attendants.

> Those people coming in and out of my house, it was like some of them was just there to make the hours, they didn't really care about his feelings or how he was. I remember one lady came and she sit there with gloves on the whole time she was there. And he wanted me to tell them when they came in that he was HIV positive. He said, "Mommy, you tell them, let them know because you know how people are." And I would, I would ask them, "Did the agency tell you that he was HIV positive?" And they would say, "No, he is?" And I would say, "Sweetheart, you can't get it like that." I would sit down and try to explain. You still have people that don't believe what you're saying, that you can't get it by just touching somebody or giving him his lunch or breakfast. And I had all the necessary tools as far as Clorox and the water and washed things down very well.
>
> I guess that's how I really came to get into home service because I just saw so many people, and I said if this happened to my son, this happened to a lot of people out there. And then when I would go to the hospital — I had become the mother of the eighth floor over there in North Central Bronx, because I was coming with shopping bags and I was bringing them up beef patties and french fries and cigarettes and all these things. And they used to come and tell Eric, you got the greatest mom in the world, and don't ever lose your family love. There was one guy there I felt so sorry for. His mother, his sisters, everybody, dissociated themselves from him and he was in the hospital with nobody, he had nobody to talk to. And he was in the final stages, he was going through a lot.

At his request, she went to talk to him. He spoke about his growing up, how he thought he and his sister were very close, but that his mother and aunt were keeping her away from the hospital. "But when you're sick [is] when you need people most."

> Out of my son's death, I think there came a lesson: that you always can help somebody else, regardless. When I came [to CHCA], I'll never forget the interview. Katherine says to me, "Why do you want to do this? You have all these certificates, that you can work in a hospital, that you can do all these things. Why do you want to go into the home?" And I said, "You know what I think? There's a lot of people out there that need me. And I think I can do the most by doing this instead of going

> to the hospital and working eight hours and just going home, because you see so many people there and you do your floor or whatever you have to do, and that's it."

Cooper's first case for Cooperative Home Care Associates was with an AIDS patient. It was "a lot of stress." She was "not ready because of memories." But her own experience helped her deal both with the man and with the dynamics of his family. "It got a little bit stressful with his mother. I tried to understand her part of it, because I knew how I was. But everybody's not alike, and regardless to how stress hits you, it doesn't hit [another] person the same way."

His mother would inspect what she cooked and would tell her to motivate her son to go outside. "[But] you can only push them so far. He's supposed to tell me what he wants to do. He's not six years old. I can't walk in here and say, 'Listen, we're going out today, and we're going to go to this place and we're going to do this.' This is a man that's thirty years old already. I mean, we'll sit down and we'll compromise and we'll do things together. But their attitude changes. I could see my son, his attitude changed from day to day."

Sometimes the patient was in a good mood, sometimes bad. Cooper got used to it and tried to explain it to his mother. Sometimes the patient didn't want to take his medication, but she always found the doses he hid. Sometimes she could tell whether or not he had taken the medication. Sometimes he didn't want to eat a basic meal, he wanted a slice of pizza. She would try to please him, feeling that the following year he might not be there to enjoy it.

Development at CHCA

An organization's culture is made up not only of the elements people bring to it, but also of what emerges as those elements interact with one another and with the outside world. From their first contact with Cooperative Home Care Associates, the talents of home health aides undergo transformation. We look at the impact on them of recruitment, training, emerging commitment, exchange of knowledge, and personal development.

Recruitment. Workers' expectations are deeply affected by past personal history and the experiences of family and friends. CHCA experiences frequently differ from those of other jobs from the outset, modifying expectations regarding human relations at work. Working relations in the home health care business are notoriously poor. Annette Dance provided an example. "I decided I was going to go to school for this thing I saw, home health aide. I figured, well, I was always in the Red Cross, I had had different types of jobs, I would do it." She received training she described as "fantastic." But "after that, forget it; they don't do anything else after that fantastic. They tell you you have to work six months to get your certificate. One year, I still can't get my certificate. They find excuses why they can't give it. You work, you go in to pick up your paycheck, there's no paycheck for you. They have a little cubicle window and the lady says, 'You don't have money here.' You walk out and they close the door on you." She went to the office to see what was wrong and was told that they had no record of her working there.

> [The company violated the labor law providing that] after seventy-two hours of work, you're supposed to be paid. They weren't paying. And people would come over there with their last token to get money. Some people would be crying there.

> These women had a household and they wouldn't get a check, and they would be crying and sometimes I had to give somebody else a token. I couldn't understand why these people were doing this, they were making the money but they didn't want to pay the workers. Then I realized maybe if they keep the money in the bank overnight, then they could get profit on it. So then I started looking to different angles of what they were doing. So I decided okay, I'm bringing the union in here, and then I started working with 1199.

Her CHCA experience was radically different. A classmate suggested that she go to a place that was opening in the Bronx, so she went, reluctantly. "I come upstairs, there was a little room, a little cubicle with this big guy, weigh like three hundred and something pounds." She talked to Peggy and Jannette, who decided to hire her. "The way they talked to me alone, I was very impressed, and I hadn't done a day's work for them. The way they speak to you as an adult, as a person, I was very impressed with that, considering where I came from."

Carrión recalled, "I was a little nervous in the sense of, oh, this is just another dead-end job. I didn't think there was a place like this. Everybody was so nice. I was kind of curious — Why are they so nice? It's like, there can't be so many nice people in this world. I stayed quiet — I'm the type that likes to stay quiet at first and just look and observe. I liked [CHCA] from the beginning, but I held back."

The Cooperative Home Care Associates staff treated applicants with dignity and validated their personal life experiences. When Bibi Yusuf went to an agency to inquire about HHA work, she was referred to CHCA. She was told that they were interviewing seventy-five but hiring only twenty-five. Bibi was afraid that she was not going to get the job. "She was asking about experience and stuff. I had no experience besides looking after my son. I did things for my father, but I didn't count that as experience. My father was sick. Now I can see how that would be experience, but I didn't really count that at the time. I'm thinking job experience." She was surprised and happy when she received the call notifying her that she was accepted.

Some applicants overcame serious obstacles in search of the higher-quality job that CHCA represented. Dominican Ramona Pichardo (interviewed March 29, 1996) said, "I was tired of working in a factory. I worked and raised my children with two jobs, sewing on a machine. I didn't want to live from the government anymore, I only did it because I needed to." But when she asked about CHCA, the public assistance social worker "told me that my English wasn't good enough to take the training. When I went back, she told me, 'I can't give you the address of Cooperative Home Care, because you don't know much English.' I said to her, 'Yes, I want you to give me the address, because I'm going to go and I'm going to struggle to be able to do the training."

Training. Many candidate aides enter training with fears and expectations of failure. Carrión recalled, "It was scary at first, because you say to yourself, Are you going to make it? I said, Wait a minute, I raised three kids, I'll make it." The training itself helps in countering bad past experiences and self-doubts. It is designed to provide social support, opportunities to learn from mistakes without feeling failure, and plenty of second chances. The training gives students an opportunity to work around their weak points. Carrión said,

> The classes give you a lift. Everybody makes you feel good. It's like you make mistakes and it's okay to make mistakes; if you did something wrong, you just do it

> all over. When we were in class, I was so afraid when they used to give us the demonstrations, how to handle a person, how to transfer them from the bed to the wheelchair. I kept saying to myself, I'm not strong enough to handle somebody, take somebody that can't walk and put them in the wheelchair.
>
> There's little techniques that they show you. But even though they show you, at first you say, "Oh my God, I'm either going to kill a person, I'm going to drop a person, I'm going to wind up hurting somebody!" But the way they teach you and the confidence they give you, it doesn't matter if they have to teach you things over. They give you the opportunity to do things over and over that you feel, even though you're doing it right, deep down inside you say, No I'm not doing it right. It might take somebody one day, it might take another person one week.
>
> Everybody's different. The written test is in English, and we have a lot of workers that are capable of understanding it but it's just like me with Spanish — I can't read it too well. [The trainers] come around, and if you're having trouble reading it, they'll translate it into Spanish, and if you can't write your answer in English, you can write it down in Spanish. As long as they know that you know what you're doing and you understand the questions. . . . I have a weak spot, and I told them from the beginning. You can set a book in front of me and I can read it with no problem, but when it comes to spelling, I'm very, very bad. Sometimes I go blank.

Students who take written tests, for example, the one for a general equivalency diploma, are often allotted a specific length of time for completion. "That's what I was afraid of. When [CHCA] gave us the written tests, they didn't give a certain time. So you could take time without worrying about it." Carrión continued:

> They teach you how to do stuff, and then the return demos, when you have to do it yourself with another person. If you did it wrong the next time, they give you another chance to do it again. And they actually show you what you did wrong, and they'll teach you again, and then you do the return demo again. And it didn't matter to them if you did it wrong two or three times. They would actually show you again. And if they had to give you maybe extra teaching on the side, they would, with no problem.

Training helped Yusuf overcome her sense of isolation as an immigrant. She met a few women who were very helpful to her, put her at ease, and are still her closest friends here because they were so kind to her. She didn't know anything about America. Everything was new to her — the people, the language, the way of living. She didn't even know there was a different language like Spanish; she thought everybody spoke English.

In training, people were very supportive and kind — friends explained procedures to her, people tried to make things easy, to make her feel comfortable and relaxed; they all traveled together and had their lunch together. She didn't feel left out or as though she was the only one who didn't understand what was going on. She was the only trainee from Guyana, but they made her feel as though she was the same as everybody else. "I didn't feel like I was the only Guyanese. Now when I look back I say, Yeah, I was, but at that time I didn't feel like it because even though they were Spanish together and they spoke Spanish to communicate, they didn't leave me out. So I felt like I was part. They were translating if I didn't understand something. So I didn't realize at the time it was a different culture."

CHCA has increasingly employed former home health aides as instructors. Yusuf, now an instructor herself, observed, "If the instructor was [an] HHA before, it made it easier, she knows what I'm going through. A nurse [might think], Oh, what a stupid question. Because right away you think of a nurse, it doesn't matter how nice the person is, right away you say, That's a nurse, it's different. This is [an] HHA, she's an assistant

instructor, but you feel more comfortable."

For those with little education, the CHCA training can be especially difficult — and especially rewarding. Ramona Pichardo, who did not have the opportunity to complete grade school, said, "I've learned a lot. When I entered the company I knew how to write a little and a little about numbers. But there I had three weeks to ground myself in a little more education. I didn't know how to use a thermometer. I didn't know what temperature was. When one is not educated, one doesn't understand what the human body is about, and there I learned a little about the human body, what a disease was."

CHCA has continual in-service training programs and provides additional opportunities for advanced training. Yusuf joined the company when it offered only a brief initial training. After being on the job, she went back for more training to become an assistant instructor.

> Everything was new. It was like learning all over again, at a much higher level. Like you took time to make a bed, you observed it and you did it, and you had to do it the right way. I would look, I would observe, I would have to assist in correcting. The nurse would be with me for the first couple of days. She would sit with me a few times and I observed how she was correcting the person, and then she would let me take the lead. Now I'm learning all these things which make sense. But at the same time, I still have to go back to my own personal experience. At the time I thought I was a good HHA, but I could have been a better HHA with this knowledge.

Continual Learning. Home health aides continue learning on the job and from other aides. Yusuf, for example, had a dying cancer patient who was often very angry and difficult to deal with. She knew little about cancer and didn't realize how much pain it caused — to her it was just another disease. But the death from cancer of a friend, twenty-eight years old and a member of CHCA's office staff, changed her attitude. "I remember, when my coworker passed away. I went home that night; I was so upset and angry and I was telling my mother, 'What kind of thing is this?' She'd never seen me like this before. I didn't have any answers."

After that, Yusuf returned to her cancer patients and put things together. "I surprised myself too. I didn't even realize I was that angry about it, and both clients passed away shortly too. It did mean a lot to me." She talked about it with another aide whose mother had died of cancer. She didn't realize at the time how much pain they go through. She came to understand that the ways patients respond have nothing to do with the HHA but that the aide has to work extra hard to make them comfortable.

Yusuf passes on her learning. "Now if a home health aide tells me, 'My client has cancer,' I ask a lot of questions: 'How is she doing, how is she coping with the pain, what are some of the things you are doing to make her comfortable, does she get upset a lot?'" When another HHA was assigned to a client with cancer who was being nasty to her, Yusuf helped the aide to understand that it was not something she was doing wrong, but something that happens when people are sick and in a lot of pain. "If I know that there's a HHA that has a cancer client, I tell them, 'Please be very understanding, don't take anything they say personally, because it has nothing to do with you. It's just the pain they're going through.' I learned a lot more being here, listening to others. Not only the instructors, but the trainees. They come in with a lot of information, they have family members, and sometimes when you're talking and they express, they go deep, they bring a lot themselves. So with what they bring in, what I read about, and talking to the other instructors, it's a big thing for me."

For some the job is a place for social and emotional development. What she learned on the job, Sarah Lee said, was how to control her tongue.

> Controlling my tongue and taking a little more than what I thought I could take. I know now what my father was talking about. When you are a child, and you see things like that, even a real young adult, you don't understand. But then when you get out here and you have to do the same thing that you saw your father do, you say, Oh man, that's what Daddy was talking about. Learning how to control. He didn't use those words, but that's what it is. You know control will take you a long way. It will take you more ways than what I was in my younger days.

Carrión commented, "[The job has] changed my personality in the sense that I'm more open. Even my own sons noticed that. They tell me, 'Oh my God, Mom, she's a big shot in her company.' Because they see me talking when my coworkers are calling the house and they see me explaining to them in Spanish."

Working with patients from different ethnic groups brings rewards to the aides as well. As Ana Cuevas (interviewed July 11, 1996) remarked,

> Every patient you go to from a different country, you learn something from. They learn something from you, and you learn something from them. The first time that I worked with a Nicaraguan, she said to me, "I want you to make me some tortillas." And I said to her, "I don't know how to make them, I can buy them for you in the supermarket." She said, "No, no, I want you to make them, I'll show you how." Then she showed me. Since I knew this was my case, my patient, I had to make her feel good. So I learned, and she was pleased.

Home Health Aides' Contributions to the Organization

The Organization's Needs

Even a conventional company requires commitment, participation, and leadership from its employees. In a democratic, employee-owned company, such needs are far more important. Yet the Cooperative Home Care Associates workforce is recruited from sectors of the population — women, people of color, immigrants, the poor — that have been largely excluded from management roles in business, government, and other major social institutions. As a result, the following organization-strengthening capacities that workers bring to the company are even more precious, and developing further capacities within the body is even more important.

Leadership. Despite their dearth of executive roles in business and government, many CHCA workers have had important leadership experience in families, churches, and community organizations. Lee, a veteran home health aide who has played many management roles within CHCA, was the superintendent of her Sunday school class when she was a child.

> That means that I opened up the Sunday school, I was responsible for getting Sunday school teachers, I was responsible for the lesson that they was teaching the smaller kids. There were three groups — the young kids that couldn't read, the grades from one to five, and from six to eight. And it was just young adults and young kids. Grown-ups would be there but they wouldn't participate. We had to learn how to conduct and control the lessons that we had to learn about Jesus Christ.

Lee's church experience helped her play a leadership role on the CHCA board, but she has also had an important part in the organization in helping to unearth and address issues that are not being openly articulated, particularly those concerning possible discrimination. This, too, grows out of her earlier experiences. "I was always outspoken. I was sassy. I was referred to as 'that sassy gal of Romer's.' Because all my other brothers and sisters are easy. I never have been. I don't expect I will be, not at this age."

Growing up, she had a reputation as a fighter. Something happened a couple of years ago that brought her childhood back to her. A girl with whom she had grown up, and with whom she used to fight, called her a "black n-b." They were in a department store, something popped, and they both got into trouble. "You treat me like a person, I'm going to treat you like one. You mistreat me, I'm gonna mistreat you." On another occasion, she said,

> My son came home one day from school saying that his teacher had called him this "n" word. And somehow I saw spots. The next morning I went out there. They knew me because I volunteered for school a lot. The teacher said she called him that name because he was acting like one. I said, "In that case, so are you." She got very insulted. So I said, "Well, how do you think my son feel? If you get insulted, he get insulted." And the school guard was with me because she knew I had fast hands, because I was getting ready to smack her face. I was called that too and I always fought. I would fight you at a heartbeat until I learned that anyone can be that "n" word, anyone, as long as you act ignorant and stupid.

Lee makes a sharp distinction between what is appropriate on the job and what is appropriate in the company headquarters. "You can't be outspoken on the job. You can be outspoken in here. Say with your coordinators, your president, Peggy, anybody else. When I was on the board, I had a lot of complaints, and they wanted to call a meeting so that they could get it out. Other people complained. So what I did, I went to Rick and I asked him to call a meeting because I had a lot of people complaining about certain things, and they wanted to talk about it in the meeting. He called the meeting, we had the meeting. So I said, 'Well, now the people that was complaining to me, now's the time to complain.'"

Betty Cooper brings PTA experience. She started as recording secretary but hates recording notes because she can't read her writing. Then she became treasurer. After that she was elected president and served for three years. She got involved with the parents, school programs, candy sales, bake sales. They also had educational programs. The PTA brought in movies, put books in classrooms, and organized trips.

At one point she came into conflict with a school cook who tried to make the kids eat food they didn't want. Cooper managed to work it out. The cook suggested that the PTA make up some menus, so Cooper decided to do that and recruited parents. She held a meeting packed with people in which everyone gave their ideas. She took the ideas back to the cook, who used them.

Some workers have wanted to nominate Cooper for the CHCA board, but she feels she isn't ready yet. She uses her leadership experience another way in the company, by encouraging others. "I said, 'There's one person up there that I'm going to push this time, Denise Clark.' I see in Denise what I saw in myself when I was involved with the schools and all these things."

Other workers bring specific talents. Annette Dance said, "I write short plays and perform for my church, and I raise money like that for my church. So in order to make

people understand I try to paint a large picture, at the same time it has some funniness but at the same time I want you to think there's a serious side to it."

Intergroup Skills. Drawing on a multicultural workforce and client base, CHCA has a pressing need for people who can bridge the gaps between languages and cultures. Some home health aides bring strong skills in intergroup relations. Dance said,

> Everybody's not like me. They tend to think I'm a little crazy, so since you think I'm crazy, I'm going to act crazy. I go to the Hispanic workers. "Hey, *mira* [look], how you doing?" I try and see if I can communicate with them. You have to kind of like break in because I think a lot of it is that sometimes they don't really understand and because they don't understand they tends to be clannish and stick together. I was talking to them and [one of them] said, "We learned English when we came here, but it wasn't enough." How are we going to bridge this gap once and for all? Because I would like to bridge it. That's why I keep telling everyone in my class, "If I tell you something in English, you've got to tell me about something in Spanish. We've got to have a trade-off."

Lee is also concerned with bridging cultural gaps. She observes that "some but not all black stay with black, some Puerto Rican stay with Puerto Rican." To get along people have to learn about one another's ways.

> If you respect my ways and I respect your ways, we can get along. But if you don't respect my ways and I don't respect your ways, we're never going to get along. Say I'm quiet and the other person is very outspoken. So you know I'm quiet, so you try to bring me out. So I can be — not as outspoken as you are, but to say what's on my mind. By me being quiet, I would tend to keep it in. But if you bring me just steady, talking to me, then you going to bring me to a place where I haven't been, which is kind of outspoken. And then you learn about how I grew up, and I learn about how you grew up. And you learn about my kids, and I learn about your kids. And you learn my ways, and I learn your ways.

Cultural and linguistic differences among clients interact with those among aides.

> You will send a black person to a Puerto Rican lady, if she can speak English. But then you don't know how she likes her food, so I couldn't cook the way another Puerto Rican lady would cook this lady food, because they are from the same heritage, so they kind of know what each other likes and how to cook it. But you couldn't bring me in there because I wouldn't even know how to first begin. [But it would help] if we could learn each other's ways — if you could learn what I eat, and how to prepare mine, and I learn what you eat, and how to prepare yours.
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> We had a team leader who couldn't speak too good English. But we all got along, we all understood what she was talking about, because we all were striving for the same goal, which was trying to get everybody involved into the company. [The most important thing is] to get people to open up and talk, to learn each other's ways, and be respectful to each other.

Realism. Cooperative Home Care Associates operates under extremely tight external constraints. While management believes that wages are far too low and wants to provide far greater educational and other benefits for workers, there is no money to do so. Workers are eager for higher wages, but many understand the necessity of accepting hard realities. "Right now, things are real bad. Every day you pick up the paper, every day you listen to the news, it's all this is cut out, that is cut out. So I know we need a raise,

but if you can't get it, you can't get it, that's all. Because Medicaid is cutting out and this is cutting out and that is cutting out. So what can you do?"

Commitment. A number of workers, including many who arrived with negative expectations based on previous experience, have developed a strong commitment to CHCA. Dance said, "Being on the board long ago gave me an idea of what's happened or what's happening, and I still feel very proud of my company. I'm in no rush to change. I remember the times when we had small board meetings; I would always bend my head, it took them a while to realize what I was doing, I basically was praying that this company would work."

Feeling angry that problems weren't being attended to, "I used to tell my president [that] this company's our baby, and it's growing. Then I told him such and such has happened, and it stinks, so the baby's pooping all over us. What are you going to do? Are you going to put a diaper on it? Are you going to potty-train it? And this is how I try to make things drastic." Dance told new graduates that the company is a tree and the aides are the roots. They have to go out and return with nutrients — good work — or there will be no branches and flowers.

Aides can see a direct connection between the quality of work and the success of the company. Ana Cuevas feels pride in CHCA's outstanding reputation: "I say that the reason we're number one is that the employees are punctual. In fact, the office takes charge of making us toe the line. Sometimes people tell me that it's very strict, but if Cooperative weren't strict, it wouldn't be in the place that it's in. All the nurses say, 'Oh, you come from Cooperative Home Care; that's good, because you are well trained.'"

Ownership. Workers had varied experiences with ownership before CHCA. One aide, for example, had owned virtually nothing in her life. "At first I was a little confused. But once I became a worker-owner and I saw the extra benefit that comes along with it, I enjoyed it. Then I said to myself, If you can really own a part of this company, wow, that's great, because that only thing I had owned was the furniture in my house and of course the clothes on my back and that's about it. I'd never owned any property, anything like that."

Lee, by contrast, had experience not only with property but with collectively owned property. "We owned our own land, and lived in the neighborhood with most of the family. From one end of the street to the other end was nothing but family. And the land goes back to my three times great-grandfather. They left it not to one person but to the whole clan. As long as the tax is paid, we own it. And he left it like that so it won't ever be sold." She believes that employee ownership motivates workers to help the company.

> You own a share of something. It's not a big share, but then you're going to work even harder to try to keep it going. And on the Christmastime, you look forward to a little extra money that you know there's something you want to do with it. And twice a year, you get a extra hundred in your paycheck, probably coming the time you especially need it. I think we all think a lot about that, because we own one share, we are going to try to make it the best company out here. When you go into a person home, you try to do the best work you can. If you see somebody out there you figure would make a good home health aide, you try to get them into this company. Because you want them to — I used to tell them — get a share of the profit. And when you know you got something good, you're going to try to keep it that way. And by we doing good jobs, the client that we working for would like pass the word on by mouth, "Oh, I got this aide from Cooperative Home Care, she's good."

> And then the one she talking to might belong to another home health care [company], but it might not be doing as good as we are doing. So then they're going to get their nurse or whoever: Can I get into Cooperative Home Care? As many jobs as we can get, that'll bring in money, and then maybe our salary go up.

Another aide feels that employee ownership gives workers a right to speak up. "This is my second time being on the board, and you know I'm always outspoken when I think I'm right. When I think I'm right, I'm going to speak. When I'm not, I'm going to be quiet, going to say nothing, listen. I think I have a right to say it because when you pay your thousand dollars for this worker-owner, it gives you a share, it gives you a voice to voice your opinion. So I think I have a right to voice my opinion when I think it's right."

Ramona Pichardo said, "It's the only company that has offered me an association of which I can become a member. I don't regret it because one receives dividends and feels like part of a family." CHCA workers feel especially privileged when they compare themselves with workers in other home health companies. As Cuevas said,

> After you have your certificate for three months, you can become a worker-owner. I think it's a good idea that the company is worker-owner, because we are the proprietors of the business, and we have many benefits that other companies don't have. At least when I meet a person in the street from another agency, I tell her about the benefits. We compare opinions of her [workplace], of mine, and they're very different. They don't have voice through a vote, they don't have a uniform allowance, dividends. As worker-owners, we have the right to vote. We vote to put in or take away a person from the board.

Many aides feel that their CHCA experience has had a major impact on their lives. Florinda Pimentel said, "It's given me another way of thinking. It's helped me in educating my children as well. I've put a lot of emphasis on them staying in school and going to university, and I have more patience to listen to them." Ana Cuevas expressed her satisfaction.

> I compare before and after, how my life was. It has changed in the sense that before I had patience and dedication and all that, but now I feel more responsible. I feel like I have to get things done, like I owe to other people to help them. I feel a more profound sense of collaboration and dedication to my job. If I don't like my job, I can't do it well. [Now I'm] more responsible, more sure of myself, I feel more womanly.

This article is from "Cooperative Home Care Associates Study: Second Interim Report," which was prepared for the Cooperative Charitable Trust. It is a segment of a larger study of CHCA that will review its background and history, the vision of the founders and its implementation, the role of organizational policy, and the contributions of management and home health aides to the company's success. For more information, write to Cooperative Home Care Associates, 349 East 149th Street, Bronx, N.Y. 10451.

Workplace Education at the Bottom Rungs

Andrés Torres, Ph.D.

In the late 1980s, observers of the Massachusetts hospital industry were predicting a severe shortfall in skilled technical workers. The Worker Education Program (WEP) emerged as one of several responses to this projected labor shortage. It was premised on the idea of an internal solution to the need for workforce development, shifting the focus from external recruitment to upgrading of incumbents — nutrition, maintenance, clerical, and secretarial staff — and from traditional classroom training to workplace education. Other features of the WEP model made it an extremely interesting experiment: it was operated by labor-management partnership, it was located statewide in nine different hospitals, it offered a college prep as well as a college-level curriculum, and it involved community colleges in a collaborative network. The author provides a narrative and assess-ment of the WEP, reporting the results of surveys and program observation. Participants, who were overwhelmingly positive in their evaluation of the program, provide insights into the ambitions and fears, needs and hopes, of lower-tier workers in the industry. The reasons for the failure to institutionalize the WEP — economic and institutional — are also discussed.

An Alternative Education and Training Approach

They filed into the auditorium one by one and took their seats. The often overlooked employees of the hospital's service and administrative departments — the clerical, nutrition, and dietary staff, the maintenance crew, and others — had come to hear about a new program that sounded too good to be true. They were offered a chance to attend hospital classes — during workdays, for which they would receive paid release time and subsidized tuition — in an education program to improve their skills, potentially leading to a job promotion. Management and the union had set up a program that would enable employees to earn college credit and advance themselves professionally.

Just before the session got under way, the curious audience was again surprised by a request of representatives of the Worker Education Program (WEP) that, rather than conform to the traditional grid of rows facing a speaker, the women and men rearrange

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their chairs into a large semicircle. The message seemed to be that employees should have an unobstructed view of the proceedings and feel they were equal participants in a cooperative enterprise. The symbolism was not lost on the audience, and indeed, this project promised to be something new.

Two years earlier, in 1988, the commonwealth of Massachusetts had ratified the Labor Shortage Initiative, a measure designed to expand the supply of workers in the industry. Health care services had become a beneficiary of economic expansion during the "Massachusetts miracle" of the 1980s, but industry observers warned that future growth was contingent on finding new cohorts of skilled labor.[1]

Under Section 83 of Chapter 23 of the Acts of 1988, the state Department of Medical Security was authorized to develop and fund programs to meet this need. Prospective trainers would have to demonstrate previous industry experience and be permitted to offer any of the following program models — direct training of health care workers, career ladder development for professionals, as well as child care opportunities and support services. Funds would be generated by a levy on acute-care hospitals of one-tenth of one percent of their gross patient services revenues.

Perceiving an opportunity to pilot an experiment in upgrading worker skills, a number of interested people formed a planning group to discuss developing a proposal focused on a work-site-based career ladder program. The group included Service Employees International Union (SEIU) Locals 285 and 767 and representatives of the Service Employees International and of the University of Massachusetts Boston, Bunker Hill Community College, and Boston's Economic Development and Investment Corporation.

The unions, particularly Local 285, were the prime movers in bringing the project to fruition. The Worker Education Program was viewed as a vehicle for attaining an important strategic goal, namely, creation of a state-sanctioned education trust fund to finance training services for hospital workers. In the early 1980s, Local 767 had suggested the same type of scheme in collaboration with a number of southeastern Massachusetts hospitals.[2] Similar programs had been established in New York and Connecticut, largely through the efforts of Health Care Workers Union Local 1199.

The initial WEP idea, submitted in the summer of 1990, was one of a number of successful proposals in an intensely competitive field. Approval for a one-year, renewable grant was secured in the fall, and the WEP began operations at the start of 1991. Funds were allocated for the program leaders to hire a small staff and set up an administrative center at SEIU Local 285 headquarters in Boston.

The contract specified that the program be established in nine hospitals throughout the commonwealth, all acute-care facilities with labor shortages, in which the SEIU was organized. The participating hospitals selected were Boston City, Burbank in Fitchburg, Cape Cod in Hyannis, Falmouth, Framingham Union, Hale in Haverhill, Hillcrest in Pittsfield, Jordan in Plymouth, and North Adams Regional.

The general model mandated a comprehensive program of career training directed at what were called Tier 1 and Tier 2 employees, workers on the bottom rungs of the career ladder in the hospital labor force. Tier I primarily includes blue-collar and manual-labor personnel involved in maintenance, patient transport, and dietary and related functions, while Tier 2 is composed of office workers, ordinarily clerks and secretaries. Members of these two groups, who typically have no college degree, face few prospects for upward mobility unless they can acquire training in a college-level curriculum.

Beyond these entry-level tiers, the hospital labor force includes employees in profes-

sional categories, for example, allied health professions, nursing, management, and medical specialists. The allied health category, often envisioned as the next logical step in the mobility path of hospital workers, encompasses various types of technical positions such as medical radiography technologist, respiratory therapy assistant, physical therapy assistant, radiation therapy assistant, and others. The WEP seeks to train current Tier 1 and Tier 2 workers for these occupations. Hospitals have traditionally filled these positions through direct recruitment from higher education institutions devoted to preparing health care professionals. The minimum requirement for such jobs is an associate degree in a relevant field.

Philosophy

The WEP, designed to test the viability of work-based training models to address hospital needs for skilled health care workers, is premised on an internal solution. By targeting hospitals' Tier 1 and Tier 2 employees and providing structured, job-related training opportunities, WEP models offer a new route to meeting changing conditions in the allied health professions. Rather than recruiting solely from traditional health career training programs, hospitals are encouraged to fill Tier 3 jobs by identifying experienced and motivated employees from within.

The initial plan identified three points of consensus among the parties, themes that ultimately provided the rationale for the project. There was agreement that (1) hospital performance is plagued by a persistent shortage of skilled personnel; (2) existing employee staff within hospitals provide a pool of potential workers to meet this shortage; (3) improving general education levels among hospital workers and providing access to college education requires a long-term commitment of the hospitals, unions, and higher education institutions.

Programmatic and Policy Goals

The four broad goals of the Work Education Program were (1) collaboration, (2) training and formal education, (3) career advancement and job restructuring, and (4) systemic change. As the project evolved, some of these goals were revised.

Collaboration: WEP's collaborative goal touched on several areas, its basic theme being to foster working relationships among critical partners who would be responsible for joint delivery of education and training services by the following actions.

To oversee WEP operations, create a labor-management advisory board comprised of representatives from hospitals, union locals, higher education, government, and the allied health professions. The longer-term purpose of the board was to secure independent financing.

Establish hospital-based labor-management committees at each site to monitor the design and implementation of each program. These committees were to identify labor and training needs, implement courses and programs, assist with outreach and recruitment, and develop and negotiate new programs.

Initiate a collaborative of health care practitioners, worker-students, and academic experts to advise on curriculum design and delivery.

Training and Formal Education: WEP proposed to develop a replicable model of comprehensive training and formal education to be delivered at hospital sites and participat-

ing community colleges. It was stipulated that courses would satisfy appropriate standards for certification, licensure, and academic credits. The final objective for an individual worker was career advancement to an allied health profession. Initially, designated occupations were radiologic technologist, nuclear medicine technologist, radiation therapy technologist, and physical therapy assistant. Six distinct processes were envisioned as comprising training: outreach, assessment, precollege education, college-level curriculum, internship, and mentorship.

Career Advancement and Job Restructuring: The originators of the pilot articulated additional goals related to hospital employment structures and mobility. WEP was perceived as a model for promoting career advancement and job restructuring for hospital workers languishing in the lower occupational categories, while opening new jobs to underrepresented populations. As the existing workforce moved up the ladder, minority workers would be recruited to fill vacancies in entry-level categories. Institutionalization of career ladder/lattice programs would help establish a mechanism for occupational mobility and increasing diversity in the labor force.

Systemic Change: Finally, WEP proposed to facilitate systemic change in the health care industry, pursuing objectives that would enhance the quality of the labor supply and improve working conditions. Suggested steps included the following.

- Develop programs to increase understanding and acceptance of the special needs of allied health care workers for workplace-based college education programs.
- Promote job evaluation and restructuring that results in increased wages and greater career mobility.
- Consult with community colleges providing allied health care programs to develop understanding of the special concerns of adult learners among the working poor and to ensure full articulation agreements among community colleges.

As can be ascertained from the preceding, WEP's original formulators were not timid in their expectations for the project. In addition to proposing a substantial service delivery component, containing three distinct program tracks — adult basic education, college courses, and internships — WEP took on the task of promoting structural changes in a highly complex and uncertain industrial climate.

In an effort to achieve these formidable goals, program leaders were to find themselves continually confronted with difficult choices. The challenge of selecting among competing demands on resources, of reexamining priorities and modifying program in midstream, became mainstays of the Work Education Program experience in the following three years. It is no exaggeration to say that WEP's proposed mission bordered on the audacious. By the same token, its vision and scope made it an intriguing and exciting experiment in workforce development.

The next two sections summarize the main phases in WEP's activities, focusing on the precollege- and college-level courses.[3] Note that this article does not address the special track dealing with a group of interns being prepared for promotion to jobs as medical radiography technicians.[4] WEP ran two cycles of classes each year from 1991 through

1993, with a total of 824 enrollments.[5] This brief account, which focuses on milestones and turning points, cannot do justice to all the intricacies and drama of an experimental program that set out to break new ground in the field of workforce development. Nevertheless it helps to set the context for assessing the WEP model.

Implementing Workplace Education: Year One

The original plan called for the first cycle of classes to begin in the spring of 1991, but as often occurs with new programs, start-up was postponed. Several factors led to an unsteady implementation phase.

For most hospitals and the lead union local, workplace education was a new experience. Few employers had a track record in delivering educational services to Tier 1 and 2 workers, much less in sponsoring apprenticeships to upgrade workers to technical positions. One important exception was the Career Ladders Program sponsored by Local 767 and its hospitals, but these sites did not start operations until Cycle 2. Local 285 had never taken on a program as ambitious as WEP. A change in the union's leadership in the final months of 1990 complicated matters. A newly elected president assumed responsibility for the program, but she had not been involved in the conceptualization or development of the WEP proposal. Indeed, it was the outgoing officer who had negotiated the original contract for Cycles 1 and 2, specifying the starting date for the first cycle.

Additional time and energy was expended in basic start-up activities: hiring WEP staff — a full-time project director, a part-time counselor, and a part-time administrative assistant; establishing a central office; and working out curricular and teaching arrangements with the community college serving as educational provider. Within a few months it was necessary to search for a replacement for the original director, who had been hired on a short-term basis to inaugurate WEP's activities but was not available to administer the program beyond the first six months. The first major modification was to delay the start of Cycle 1 to the summer of 1991. The permanent program director came on board in June, just prior to the launching of classes.

Site Dispersion

Several reasons contributed to these faltering beginnings, but perhaps none was as important as the overly ambitious scope of promised activities dating from the 1989–1990 proposal-development phase. The goal of establishing the program at nine different hospital sites was especially demanding. No other project funded by the Department of Medical Security came even close to serving such a range of sites.

This predicament stressed resources by forcing staff to reproduce start-up activities in many organizational contexts. In January through March 1991, the first project director spent most of the time on the road working out final agreements with individual hospitals. Several issues had to be spelled out in terms relevant to each site: specific arrangements for clinical training, that is, assuring the logistical and mentoring aspects of the apprenticeship piece; release-time agreements; on-site academic training; achieving an accord on upgrading participants during and after training.

Program staff had to contend with a wide range of hospital settings in the nine locations: urban, suburban, and rural; community-based and teaching; private and public. Taking the differences in course offerings and sites into account, there were nine distinct program activities during Cycles 1 and 2. The demands thus placed on program

and hospital staff and the educational provider were enormous.

Determining curriculum was not as easy as one might expect, as illustrated by the words of the second program director.

> When we began offering courses in the workplace no one really knew what to offer first. Although assessments were done in some locations, they were more focused on academics than on assessing workplace skill level. In addition, no one knew the educational needs or desires of the workforce. The workers themselves were initially wary of the program. They were concerned about confidentiality — whether their supervisors and peers would find out what they did and didn't know.[6]

Beyond this was the complexity of WEP's program design. With three tracks, each serving different types of workers, it was unreasonable to assume that all hospitals would support each type of activity. Following the course of the peculiarities of each site's operations was no easy matter. Needless to say, concentration in fewer, more closely situated sites would have made the start-up phase more manageable.

Ironically, the Service Employees International Union's willingness to operate a training model in so many hospitals made its proposal quite appealing to the Department of Medical Security (DMS). WEP was the only statewide model, all other DMS-funded projects having been approved for individual facilities mostly in the greater Boston area. WEP allowed DMS to show the Massachusetts elected officials that it was servicing a broad spectrum of the health care sector.

From SEIU's point of view, a broadly dispersed program fulfilled certain goals. It placed the union in the position of taking on a risky, yet potentially rewarding project at a time when it was looking for ways to stimulate membership involvement in the life of the organization. WEP also offered a chance to reach locals in the western part of the state, where workers rarely have access to innovative opportunities for career advancement.

Finally, during the early period of proposal development, it was hoped that the "distance-learning" model could be linked to fiber-optic technology. WEP would then have been positioned on the ground floor of a major breakthrough in work-based education. However, this idea has yet to bear fruit in the commonwealth, as the telecommunications industry must still establish the commercial feasibility of this technology.

If program staff saw this dispersion as problematic for WEP's implementation phase, union leadership seemed willing to face the consequences, given the political importance of piloting a statewide model. Other issues affected program implementation, some that could be traced to initial conceptualization and some that surfaced in the first year, especially during Cycle 1.

Unrealistic Goals

Unrealistic goals had been set with regard to the outreach-assessment-placement process for the first two cycles. The original proposal to the Department of Medical Services of June 28, 1990, had promised that, for Cycles 1 and 2 combined, WEP would conduct assessments on 300 student-workers and enroll 500 workers in the full range of educational programs. These figures turned out to be much too ambitious. By the first cycle, 64 had been assessed and 48 enrolled. By the end of Cycle 2, a total of 108 had been enrolled.

The first project director said that WEP faced the dilemma of a well-meaning but

"grandiose concept." Everyone underestimated the required start-up time. The union could have used more lead time to set up office facilities; as it turned out, the project director found herself having to do this alone. At one point there was uncertainty even over the future existence of DMS, with rumors circulating in political arenas that the agency was targeted for elimination. This raised doubts about whether funds would continue flowing to WEP.

Another problem surfaced in connection with the plan to set up an internship component for physical therapist assistant (PTA). Initially, WEP proposed to cover two technical areas, PTA and medical radiography technician. But preliminary canvassing of educational providers indicated that community colleges were less than enthusiastic about innovative curriculum delivery to hospital work sites. Most colleges already had sizable waiting lists for their regular programs in this field, and WEP staff sensed that these institutions were reluctant to enter into new relationships that would require special articulation agreements.

By summer 1991, labor-management committees were being encouraged to recruit for the medical radiography, as opposed to PTA, internship slots. At least in the medical radiography area, the program could count on a solid relationship with Bunker Hill Community College, which had firmly committed to the project. Later, in 1992, it was decided to drop the idea of a PTA internship and focus on the medical radiography internship.

Fortunately, the DMS was extremely helpful in adjusting the program's scope and amending the original goals and expectations. Program staff worked closely with the state agency during the first year, covering Cycles 1 and 2, to modify target goals. Once it became clear that the original numbers were unrealistic, they were adjusted to take into account the complexity and scope of the program design.

Staffing

Relying on one full-time project director and the two part-time assistants, one counselor, one clerical, the core WEP staff was grossly understaffed for the task at hand. Even the educational provider (see below) was able to hire only fractional time of certain administrative and academic personnel to supervise delivery of educational services from pre-college courses to the internship component. Limited funding for personnel was a stark example of the gap between goals and available resources.

Community College

As with the labor-management partners to the project, WEP was an experimental effort for Bunker Hill Community College, the prime educational provider, which had not participated in a program quite like this. The college has expertise in training students for the allied health professions, but regular classes are held on campus. Clinical training is often arranged with cooperating hospitals, but students are not employees of the sponsoring hospital, as in the case of WEP. It took awhile for college staff to become familiar with the WEP model and define its functions and responsibilities.[7]

In addition to responsibilities related to the medical radiography component of WEP — with attendant concerns about delivering a clinical program that would meet accreditation standards — the community college had to identify appropriate teaching staff for the precollege- and college-level courses to be given at hospitals. In the first year, time limitations were such that faculty were not given the opportunity to develop and prepare curriculum, especially for Cycle 1.

Assessment

There was disagreement over the student assessment policy, with WEP staff and union officials questioning the appropriateness of computerized testing procedures and instruments used by the educational provider. For Cycle 1, consisting of developmental courses in English as a second language/Adult Basic Education and introductory college courses, testing was conducted for all applicants. But program staff felt that students were intimidated by the examination process, and subsequent cycles basically dispensed with these tests.[8] Unfortunately, in Cycle 2, consisting entirely of medical terminology courses, a number of students found the course work too demanding and dropped out, suggesting that assessments might have been useful in identifying unprepared learners.

Adjustments

Given the extremely ambitious scope of the original plan and the many constraints with which the program had to contend in the first year, the program delivery experience was quite remarkable. With Cycle 2, operations became greatly stabilized as the various institutional partners learned from the experience of Cycle 1, improved coordination, and made key adjustments, of which there were several. The most significant modification was the scaling back of participant numbers and program complexity. The original goal for classroom participants was determined to be wholly unrealistic and reduced to about a third of the original target (almost 500 for year one).

An important transition occurred between Cycles 1 and 2. The shift from a curriculum of precollege- to college-level courses, all in medical terminology, in effect represented a shift in focus from Tier 1 to Tier 2 workers, who are better prepared academically and primarily employed in suburban hospitals. Some observers and participants in program operations worried that WEP might abandon the original commitment to Tier I workers, who have a special need for college preparatory courses. In year two, the ratio of college to precollege courses became more skewed, with nine courses in the former and three in the latter. It appeared that in the tug of war over how to deliver curriculum, the needs of Tier 1 workers were being neglected, which seemed to be the price paid for the Work Education Program need to retrench on its original goals.[9]

Despite the somewhat chaotic atmosphere of the opening year, WEP was successful in mounting the first statewide program of work-based training programs. Recognition of this accomplishment came when the program received renewed DMS funding for the second year. WEP's proposal was among the highest rated of all submissions to the second-round competition for the Labor Shortage Initiative.

Consolidation and Expansion: Years Two and Three

By early 1992, program staff and advisory board members were expressing a highly positive, upbeat view of the Work Education Program's development. Cycle 2 had been a big improvement over Cycle 1, and Cycle 3 was proceeding well. Considering that an entire year's educational programming had been compressed into a six-month period, there was reason to be relieved that the birth pains were over.

There was greater competition for entry into courses, suggesting that the more ambitious and better prepared workers would enroll. WEP found it difficult to meet the demand for classes as the majority of participating hospitals expressed the desire to offer at least

one course each cycle.

In mid-1992 Cecilia Wcislo, the union president, offered an assessment of WEP progress. Despite occasional problems with individual supervisors on release-time issues, the recent Cycle 3 graduations demonstrated a high level of employee identification with and support for WEP. Employees, learning that they could meet a challenge, and feeling smart, displayed increased feelings of self-esteem.

According to Wcislo, WEP was encouraging people to realize that it is never too late to learn and advance themselves. Some supervisors and managers were surprised that workers were so positive about this experience, perhaps harboring envy of the enthusiasm of many workers. Within the union, there had been a lot of positive feedback on WEP's progress. At their convention, stewards and members voiced great support for WEP. The exceptional competence of its project director, who had been key to the success of the previous year, was a critical factor in the program's improvement.

A further sign of the overall positive assessment of WEP was provided by the Department of Medical Security when, in the summer of 1992, it awarded WEP a third grant for $425,000. These funds would allow the program to service some 250 students in Cycles 5 and 6 and to continue support for the eleven medical radiography interns.

Release Time and Other Coordination Issues

By mid-1993 there was a marked improvement in the refining and handling of release-time policy at the various sites. The following fundamental issues were discussed by the WEP Advisory Board during 1992. Tensions may arise between front-line supervisors and their superiors if the hospital fails to inculcate a long-term view among the former. In the case of English as a second language courses' affecting specific departments, some unit heads become concerned because backlogging work is burdensome. For example, in transportation departments, employee schedules are driven by the need to service patients on an on-call basis, a situation further aggravated by the hospitals' pattern of eliminating positions first in Tier 1 jobs like housekeeping and dietary units, most of which were especially lean in the existing economic climate. These problems, especially scheduling, are not as severe in clerical units, where staff have greater flexibility in scheduling their workload. It is relatively easier to backlog, speed up, or share tasks with coworkers, thereby fitting class sessions into the daily routine. Generally, supervisors want quick payback for the adjustments they are asked to make. A six-week computer course targeted at receptionists and typists quickly gains support because results are readily seen.

There was also tension among workers. Competition, resentment, increasing workloads on nonparticipants, came into play. All unit employees, not just the students, need to be made aware of the changes implied by WEP participation. How can these issues be dealt with? The more directly a hospital can involve supervisors, perhaps as mentors, the more support it gains for the program. This implies a philosophy and work environment aimed at bonding rather than separating workers and management.

Suggestions for improving coordination included written agreements between the union and hospital laying out the terms of WEP participation; invitations to supervisors and management to attend graduation ceremonies; making the program more visible within the hospital and the community.

It also helps to make unit directors responsible for collecting sign-up sheets so that they know who is applying. Supervisors resent being informed at the last minute that a member of their department is enrolled in a program. Somehow the hospital and WEP

have to reassure supervisors that they will not lose valued employees to another unit or that their budget lines will not be eliminated when WEP students are promoted. Finally, unit supervisors have to know that a high-level administrative officer such as the vice president of human resources endorses the entire effort.

Negotiating the Future: Uncertain Prospects

In the fall of 1992, during collective bargaining negotiations with two participating hospitals, there emerged early signs of hospital resistance to the creation of a permanent trust fund that would guarantee long-term survival of WEP. The lead union sought to include this item in the new contract but was rebuffed by employers. An important underlying factor contributing to this resistance was the perception of WEP as a union-driven project. Some management personnel believed that WEP was not really a joint project. Despite a great deal of effort expended by their organizations, they felt that the union received top billing, reflected, for example, in the WEP letterhead, which did not list the names of participating hospitals.

The union rejoinders — that it contributes many of its own resources like overhead and staff time, that graduation ceremonies are held on site and amply recognize employer contributions, that employees regularly express gratitude to their employers for allowing them to participate in WEP — all failed to dampen the criticism. It was becoming evident that the management side did not view WEP as a long-term effort.

In the third year of operations, with expanded support from DMS and two years of experience under its belt, WEP's course offerings and the number of students enrolled surpassed the combined levels of the previous two years.[10] The year was characterized by a much smoother and steadier pace of activity even with the greater scale of programming. By late 1992, planning had already begun for Cycle 5 classes, and labor-management committees had refined the complex process of outreach, recruitment, and selection.

Assessment

With the entry of new community college partners in western Massachusetts and Cape Cod, the issue of assessment policy was resurrected. Both educational providers expected Work Education Program applicants to follow normal procedures adopted by the institutions for entering students. Some workers were not given release time for testing; others were intimidated by the process, a problem WEP had worked hard to avoid in the previous cycles. A three-hour written test at one school led to friction between the educational provider and WEP representatives. Since courses for Cycle 6 were not offered at these sites, the issue was not revisited. Applicants at the second school expressed discomfort and anxiety over having to take a computerized test, saying it was an uncomfortable experience and affected their performance.

Introduction to Health Careers Seminar

An intensive noncredit course of five three-hour sessions was devised to offer career orientation and assessment to hospital workers. Designed to counsel workers in creating individual education plans and to invite a series of guest speakers from various hospital departments, it was successfully piloted at a WEP site during the summer. The workers were given a comprehensive tour of the hospital to familiarize them with its various departments and functions. The project included a special component dealing with

adult-learner study skills. WEP staff developed a training program in basic learning methodologies for adult workers intended to aid them in retaining course content in conjunction with other orientation activities. Topics included myths and realities about older students, note taking, and reading techniques.

WEP Contributions to Hospital Employees

Responses to worker surveys provide additional information on WEP's effectiveness and impact. Employees reported a high degree of satisfaction with the program, variously expressed to evaluators in telephone interviews.[11]

An overwhelming number of learners, more than 90 percent, felt that the Worker Education Program should continue. Given the opportunity, the great majority would have liked to go on in the program. Most participants expressed the view that their WEP courses helped their job performance and improved their grasp of basic skills in reading, math, and English.

Employees proposed no fundamental changes in the program design beyond that of expanding course offerings and providing greater access to those who were unable to gain admittance during the first two years. A number of suggestions for improving WEP were gathered.

> Offer it to more people; have several classes going on at the same time so more can participate.
>
> I really enjoyed the program; I can't imagine what would improve it, possibly the time of day, if it could be in the morning. I found it difficult to leave what I was doing at three P.M.
>
> More courses should be offered; if two people want to take a course they have to draw straws. Offer more courses so that those without seniority would be able to get into a course. Make the program more available, have more slots.
>
> It is the best educational program I've seen in the health care system. Lab tech, med tech courses, and business courses would interest me.

The most common response was simply "Nothing" or "Nothing I can think of."

Worker-students gave highly positive ratings regarding the classroom experience. They felt comfortable about asking questions in class and were capable of keeping up with assignments. They were enthusiastic in their opinions of their teachers and enjoyed having coworkers as classmates. The course material covered topics relevant to their current functions or potential job positions. These themes were affirmed when workers were asked what they most liked about WEP.

> My classmates were very friendly and it made it easier to study together.
>
> They try to help me; for me it was the opportunity to develop English skills.
>
> We had an excellent teacher; she had a way of relating things to everyday life so you could remember them.
>
> It was enjoyable; the teacher made you feel good about yourself.

Enabled me to feel like I can accomplish something.

The satisfaction of getting an A.

It taught me a lot of things I use on my job.

Helped me do a better job.

Above all, they cherished the convenience of workplace education and the fact that it was subsidized.

Bringing the education to the workers so they can take advantage of it.

It's a nice opportunity for people who can't afford to go to college.

The courses are offered on hospital grounds.

The work release time and it's free.

Nevertheless, they felt stressed by the challenge of returning to the classroom and keeping up with an academic course load while performing their regular job. This issue was dominant when students were asked what they liked least about the program.

It became too much once in a while. I became overloaded with taking care of the house, working eight hours and then a few hours of homework; sometimes it was just too much.

The long hours at home that it took to study.

I didn't have enough time to do my homework.

WEP's Meaning for Workers

WEP succeeded in tapping into an unmet demand for self-advancement among a traditionally overlooked sector of the health care labor force. Employees consistently attested to this opinion in their interview responses. The most important reasons workers gave for their interest in the program were, in order of frequency, to get a better job, self-improvement, and to do a better job.

There is a lack of mobility in the hospital; I want a better job.

I'm trying to get a promotion, to get a better job.

To learn more about medical technology.

To better myself as a black man.

To see how well I could do as a student.

Just to get back to being a student.

To go back to refresh myself from high school, I've been out thirty years.

For customers who come to my work, I want to do a good job for the hospital and the patients.

To be more efficient at my job.

To try to better my skills.

To improve my job skills and get a better awareness of what's going on and basic self-improvement.

Knowing that our jobs may change, new jobs may have prerequisites and this course might be a prerequisite.

I was doing the same thing at the hospital for twenty-two years and I needed a change; it offered a change.

I want to go on from where I am; I'm in a dead-end position and I couldn't afford to pay for classes on my own.

At a time when the country worries about declining productivity, WEP demonstrated that workers have more than enough motivation to seek upgrading. For every person enrolled, there was another who, for one reason or another did not participate.[12] The majority of these nonparticipants were disappointed about being unable to take a course or to become involved in the internship component.

Access: Who Can Participate?

Comparing participants (Ps) with nonparticipants (NPs), one finds that the latter were more likely to have attended fewer years of high school and that the former were are more likely to have some exposure to college.

Nonparticipants tend to come from lower-income households than participants. For example, proportionately more NPs live in households from the lowest income bracket; in the next highest income category a greater proportion of P households were represented than NP households.

White workers were somewhat overrepresented among the participant pool. Conversely, minority workers were overrepresented among the nonparticipants. The available evidence points to factors having to do with seniority, educational and income background, and the relatively greater structural difficulty of incorporating Tier 1 workers, compared with Tier 2 workers, in these kinds of programs. Survey responses, as well as interviews with program operators and hospital personnel, confirm that Tier 1 employees, bound by tighter work schedules and with jobs in departments more seriously depleted by personnel retrenchments, are less able to work out flexible arrangements that permit participation.

Added to this is the general finding in labor-market studies that show an interplay of education deficits, economic dislocation, and discrimination in accounting for the overconcentration of minorities in lower-paying jobs.[13] This would explain why more minorities are to be found in Tier 1, as opposed to Tier 2, jobs. There is no evidence, however, that WEP discriminatory practices were conducive to the underrepresentation of minorities in the program. Indeed, WEP staff were quite sensitive to this issue and took steps to address it.[14]

Participation rates, defined as the ratio of participants to the total interviewed population, were determined for each race and gender group. Rates were highest for white females, followed by white males and minority females, who share virtually the same rates, then minority males.

It is also the case that seniority among participants, measured by years of employment at their hospital, is highest for white females; they are followed by white males,

minority females, then minority males. In general, the race and gender pattern of participation conforms to the race and gender pattern of seniority. This was similar when comparing job tenure — years of employment in the current job — among workers.

Since seniority was a principal criterion in the selection process, it is not surprising that minorities, who entered the Massachusetts hospital workforce more recently, were slightly underrepresented. Lower average educational levels of minorities may also have contributed to underrepresentation when assessments were used to select participants. Finally, the relatively low share of minorities in the total pool of inquirers and participants, 21 percent and 14 percent, respectively, in Year 1, attest to the primarily suburban and rural distribution of WEP hospital sites.

Aside from these background characteristics, two factors were most strongly identified as explaining nonparticipation. One group apparently did not receive enough information about the program to warrant further follow-up and another group was beset by pressing family obligations that inhibited their ability to participate in the program. Other reasons concerned release time and scheduling problems. Issues related to spousal/peer support, self-esteem, and health status were of minor importance.

Evaluators had initially conjectured that the *form of communication,* whether written, oral, or other, might be instrumental in determining who ends up as a participant, but there was no evidence that any particular source of information was more important for learning about WEP. In other words, it appeared that both participants and nonparticipants learned about the program through the same information networks.

What Influenced Course Completion?

Completion rates appeared to be correlated to tier level. They are highest for admissions and discharge personnel, technical assistant/professional/technician, clerks and secretary/receptionists, all Tier 2 positions. Completion rates are lowest for housekeeping, food service, and semiprofessional workers, the first two of which are Tier 1 positions. Educational levels varied somewhat between completers (Cs) and noncompleters (NCs). The former were more likely to have had some college experience while the latter were less likely to have been enrolled in a training program prior to their involvement in the Work Education Program.

There is some indication that initial *motivation* for taking a course differed between completers and noncompleters. Giving the single most important reason for being attracted to WEP, NCs emphasized the opportunity to *get* a better job. In contrast, for Cs the most important attraction of the WEP was to *do* a better job. NCs saw WEP as an opportunity to move up the job ladder, while Cs thought in terms of improving their performance, signaling that they were relatively more content with their current position. It is not clear from the information at hand how these different perspectives may have determined the difference in outcomes.

Unsuccessful students were asked to give the most important reason for not having completed their course. Among noncompleters, the majority pointed to personal problems, alluding to family, household, and other constraints on their time and energy. Of lesser importance were course-related or job-related issues.

Participants commented on some of the program-related aspects that came into play. NCs were more likely than Cs to feel that the teacher proceeded too rapidly and that they had a hard time understanding the class discussion or keeping up with assignments. They were also less likely to feel comfortable asking questions in class. Finally, those

who did not complete their course were less likely to consider that the course material was related to their jobs.

On the whole, NCs expressed having received less interpersonal support from their families and networks at home and at work. The greatest disparity between NCs and Cs in support received was in their relationships with nonspousal family members — children, parents — course teacher, WEP staff, and work supervisor. In other words, the NCs found these persons, in the order listed, less helpful than did the Cs.

Additional insights may be gleaned from noncompleters' comments about WEP. NCs were less likely to rate their teacher and the course in general as excellent, although they had given overall positive ratings for both. NCs were less likely to feel that their WEP participation had helped them significantly in their present jobs and in improving their reading, math, and English. Also, they were less inclined to give an excellent rating to WEP.

Overview of Accomplishments

Besides the comments provided by worker surveys, WEP's accomplishments were confirmed by evidence from other aspects of the evaluation process.

Reaching Bottom-rung Workers

Outside the Boston area, where most Work Education Program sites are located, the population of Tier 1 and Tier 2 health care workers is comprised primarily of white females. This is a labor pool characterized by relatively stable employment conditions: average length of employment with the current hospital was 7.5 years, and average length of tenure in the current job title was 5.5 years. But even though they enjoy a measure of security, their standard of living is quite vulnerable, and their opportunities for advancement are limited. Two-thirds of WEP workers come from households with less than $40,000 annual income, and one of every four belongs to a family with less than $20,000 income.[15] Typically, their schooling consists only of a high school diploma or general equivalency diploma (GED).[16] Their average age is in the mid-thirties; two-thirds of them are married, and a similar number have child or adult care responsibilities. This presents a picture of a labor force threatened with stagnation in terms of career advancement. They are approaching maturity in employment experience but lack the preparation to move up the job ladder, and they are constrained by family obligations and finances from pursuing higher education.

It is a major accomplishment of WEP that it successfully reached Tier 1 and Tier 2 employees and provided an alternative path of career advancement. The rise in female participation has been one of the most fundamental trends affecting the U.S. labor force since the 1950s. WEP has shown that it is possible to devise educational programs sensitive to the needs of this expanding workforce so that the initial gains in *access* can lead to strategies for *mobility.*

Labor-Management Collaboration

WEP created several mechanisms that effectively directed program planning and implementation, including an overall advisory board with management and labor representatives from eight hospitals as well as education providers, local labor-management committees responsible for overseeing operations at individual sites,[17] and collaboratives of

professionals to advise on curriculum design and delivery. Each of these groups, assisted by WEP central staff, met regularly. Such activities demonstrated the potential for fruitful interaction between management and labor in an important service industry.

Cost Effectiveness

Compared with other programs sponsored through the Labor Shortage Initiative, the Work Education Program was quite efficient. WEP's cost per worker served was well below that of other projects offering training to Tier 1 and Tier 2 workers. WEP's average was $1,000, compared with $1,479 for non-WEP projects in 1991, and $736 versus $1,188 in 1992.[18]

Add to this the fact that WEP was responsible for servicing a sizable proportion of all unskilled workers reached by the Labor Shortage Initiative (LSI), and one can appreciate the importance of the program in the context of the state's overall strategy for upgrading workers in the industry. For example, although in 1991 it was one of five service providers funded through the LSI, WEP assisted *two-thirds* of all Tier 1 and Tier 2 employees. In 1992, WEP, as one of nineteen such programs, aided *one of every four* targeted workers. In so doing, it helped bring down the average cost for Department of Medical Security programs statewide.

Additional Accomplishments

By the summer of 1993, WEP had attained nonprofit status, allowing it to apply for grants and accept funds from charities. At least twenty-five of the employees who participated in Cycles 1, 2, and 3 received promotions at their jobs. Acknowledgment of WEP's accomplishments came from several sources. Based on its track record, the program secured additional funding from Federal Literacy funds to operate a basic skills/literacy training project at a non-WEP hospital. Subsequent to the initial grant in 1991, WEP successfully competed for renewal grants through the Labor Shortage Initiative for two more years, obtaining funds in both to expand the scope of activities.

Additional funding was approved for WEP to support the radiography interns, without which their program would have been terminated at the end of 1993. Participating hospitals also agreed to subsidize employee-interns beyond the grant period.

WEP, a finalist in a statewide competition for recognition of excellence in workplace education programs, was given extensive coverage in the local press throughout the state.

Sources of Success

The evaluation process revealed that three critical factors contributed to these achievements. WEP benefited from a highly talented and energetic program staff dedicated to the concept of work-based training for rank-and-file workers. The instructors were capable of advancing an innovative program in an environment fraught with potential conflicts among various institutional actors. The program director was particularly adept at managing the enterprise. The program leaders showed a willingness, in midstream, to experiment with new program ideas and adopt necessary modifications. In addition, the performance of the staff of the principal educational provider, which took on a risky venture, and key administrative personnel in a number of hospitals, who were genuinely committed to WEP, were instrumental in its success.

Within each hospital site, WEP operators skillfully mobilized an intricate network of

personnel who became the organizing agents for planning, outreach, and implementation. Human resources, largely on a volunteer basis, were gathered from senior and junior management and from labor's rank and file and stewards to form a collaborative relationship. In general, programs were successful to the extent that these indigenous resources coalesced around the program. In those few instances where a history of conflict or distrust reigned, where there was little parity between management authority and employee rights, programs failed to get off the ground or were less than effective.

Finally, the program would not have flourished without the existence of a motivated workforce, which seized upon an opportunity for advancement.

Impasse on a Lasting Agreement

The key strategic goal, a least from the union's point of view, was to obtain employer agreement for the creation of a permanent trust fund. By demonstrating how an educational program could raise skill levels and morale, WEP would be recognized as a type of service that merited long-term financial support. It was hoped that after the precedence of the LSI, in which employers were assessed moneys for a central fund, hospitals would continue to replenish resources for educational and training programs. A formula specifying the amount of employers' contributions to the fund would be negotiated as part of the collective bargaining agreement.

Despite a consensus by both sides that WEP was an effective program, labor and management could not reach an agreement on the creation of a trust fund. Essentially, management was reluctant to make a long-term commitment, and the WEP Advisory Board was unable to exert the necessary pressure to broker an agreement on this vital ingredient.[19] There are several reasons for their failure to arrive at consensus.

Financial Incentive

In the first place, there was no strong monetary incentive for continued hospital support. Employers were clearly willing to endorse WEP if they were obligated to contribute funds to the LSI as a way of recovering some of the resources they were required to allot to the legislation. But with the ending of the initiative, they preferred to retain control over these funds without having to earmark them for a specific purpose. In at least one case, the employer stated that it was willing to operate a WEP-style program on its own without having to share oversight functions with the union.

WEP as a Union Project

Rightly or wrongly, management perceived the Work Education Program as a union-driven project. It was therefore problematic for them to consider it a proprietary project, to contend with the resentment of nonunion employees who felt they should receive more training services, and in general to watch the union take primary credit for WEP. The union's insistence that it did not control WEP or desire to reap more than its share of recognition failed to reassure management. The uneasiness in relations between the two partners contributed to the lack of consensus on the trust fund issue. Although not formally spelled out in WEP's original set of goals and objectives, it may be said that labor viewed the program as an aid to fostering union building. Needless to say, this implicit goal was not shared by management.

From the onset, union officials saw WEP's potential for strengthening internal organization.[20] By offering a new service to members, the union hoped to enhance worker

loyalty. The existence of WEP would encourage greater participation in the union's total range of activities and affairs. It might contribute to leadership development by helping to identify employees who were interested in personal growth and career advancement. Union stewards at local sites, key in monitoring program activities, would be empowered with a new responsibility and respect if for no other reason than their ability to assist members in gaining admittance to the program.

In short, the union considered WEP not only as a provider of basic literacy or health care training but as a logical avenue into its broader program for leadership development, in which members were learning how to run meetings, engage in public speaking, and so forth. While WEP concentrates on developing skills, the union focuses on leadership development for staff, stewards, and potential rank-and-file leaders. Labor has an obligation to its members that transcends simple business unionism; and in pursuing this role, it can contribute to the well-being of the nation. Cecilia Wcislo, Local 285 president, stated, "The role of the union is to help empower workers, to see the workers as an untapped resource; in Europe, management and labor see the lack of worker education in the United States as a joke; European employers see this as an advantage they have over U.S. workers. The United States is thirty years behind the cutting-edge developments in this area."[21]

Unfortunately, management was unable to identify a corresponding set of implicit goals in WEP that would make the program equally appealing in the long run.

Raising Unrealistic Expectations

Does WEP's success have the ironic effect of raising false expectations? According to one view, expressed by a Massachusetts official who was a representative on the WEP Advisory Board, WEP must be careful about offering a carrot it cannot guarantee to deliver, that is, promotion to a higher-paying job. This had occurred with apprenticeship programs in other industries, especially the building trades. By the late 1980s the construction industry had fallen on mighty hard times and many workers in the field were unemployed. The same had occurred with those involved in training programs for dislocated workers funded through the Jobs Training Partnership Act.

There is the real possibility that there will be no job openings at the end of an educational process, leading to problems with worker morale. It is not a happy task to limit enrollment, as in state apprenticeship programs that limit the flow of candidates, but programs like WEP would have to deal with this issue sooner or later.

Job Training in an Uncertain Industrial Environment

There seemed to be no compelling agreement on the type of training that hospitals wanted for their employees. This was demonstrated at the April 29, 1993, quarterly meeting of the WEP Advisory Board devoted to the subject of education and training requirements. Several areas were identified as potentially important for worker training. Some growing technical fields, for example, magnetic resonance imaging and radiology, will require licensing, for which there will be a tremendous need to prepare workers for examination. According to one executive, hospitals will seek to expand the skills base of existing employees through cross-training policies as an alternative to hiring new personnel. Presently hospitals rely greatly on training services from equipment suppliers whose training programs are too short and superficial.

Another view argued for the importance of orientation programs to phase in worker-

students before actual course work begins, which is especially important as a strategy to overcome intimidation by the assessment process. According to another management representative, it is simply too presumptuous to try to predict training needs for large groups of employees. Between the economic recession and talk of national health care reform, the industry picture is too volatile for anyone to forecast the future configuration of labor-force needs. In the meantime, the most important step is to draw up individual training plans; for example, clerical staff being reallocated to new functions or units have to learn new computer software programs. In the public sector, where collective bargaining prevails, downsizing leads to a more senior workforce in which many employees have to learn technologies to which they have not been exposed.

It was clear from this dialogue that no strong agreement was emerging on a focused training strategy, one that would encompass all participating hospitals. It was equally obvious that hospital representatives were less enthusiastic than their union counterparts about forming a long-term relationship.

Finally, trends throughout the decade confirm that restructuring in the hospital industry continues apace. Since 1990, eighteen Massachusetts hospitals have closed. The total number stands at 81, down significantly from 1970, when there were 127 acute-care hospitals in the state.[22] We live in an environment of great uncertainty, in which projections of labor demand — quantity and quality — are extremely difficult to estimate. Despite the participants' inability to institutionalize WEP's original model, this experience can help identify the conditions for future workforce development policy.[23] It is incumbent upon the three principal stakeholders in this area — labor, industry, and government — to establish a common ground of agreement. Union members may have to consider a trade-off between wage demands and education/training programs when it comes time for contract bargaining. Labor will have to come up with more specific proposals regarding the type of training it envisions being supported by a trust fund. Labor needs to develop its thinking about cross-training and existing proposals for a more flexible workplace without sacrificing job security and quality of life within the work site.

Management will have to look beyond the short term, beyond purely economic factors, in determining the worthiness of educational programs. Employers cannot continue to argue that their exclusive role is to satisfy business criteria. The corporate sector has a social responsibility to the communities in which it operates, beginning with the clients it serves and the workers it employs.

The Worker Education Program has shown that a labor-management partnership can deliver training which meets industry needs, raises worker morale, and is cost-effective. Unfortunately, it required externally generated pressure, by the Labor Shortage Initiative, to induce industry's participation. This is where the public sector comes in, perhaps in the form of subsidies, perhaps as a "nudge" factor in pushing industry to collaborate with labor.

In the meantime, WEP has provided us with a rich experience in workplace education, one that will inform and influence future developments in the field. Worker participants sent a clear message of support for the WEP model of education. Hospital employees currently confined to the bottom rungs of the occupational ladder are eager to move up into more challenging, better-paying positions. Our society must create the conditions for a high-skilled, high-wage path toward economic prosperity and social justice. If we decide to pursue such a strategy, the WEP and similar approaches will be in the forefront of a transformative education and training system.

This article is based on interviews with hospital workers, management, and WEP program staff. The analysis draws on limited class observation, discussions at WEP Advisory Board meetings, and survey responses from 231 WEP participants. In addition, I reviewed WEP program records and reports. For detailed survey results, see the final report of the WEP Evaluation Project, Andrés Torres, The Worker Education Program: A Summative Evaluation (Boston: University of Massachusetts, Center for Labor Research, 1994). I thank Michael Bishop, Françoise Carré, Maria Estela Carrión, and Christine Hayes-Sokolove for their able assistance in the evaluation project and James Green for his comments.

Notes

1. Massachusetts Hospital Association, *Career Opportunities in Health Care* (Burlington: Massachusetts Hospital Association, 1989); Massachusetts Hospital Association, *Health Care Personnel: Avoiding a Crisis in the 1990s* (Burlington: Massachusetts Hospital Association,1989). Commonwealth of Massachusetts, Department of Medical Security,*Labor Shortage Initiative: Request for Proposals* (Boston: Department of Medical Security, 1990, 1991, 1992).
2. The Career Ladders Program at Cape Cod Hospital is a model of labor-management partnership, offering long-term occupational advancement in an economic region dominated by seasonal and part-time work associated with the tourist industry. Michael Bishop, *Opportunity Is the Rule, Not the Exception* (Boston: University of Massachusetts, Center for Labor Research, 1993).
3. This discussion covers only the DMS-funded programs operated by WEP. The organization was successful in winning other grants during and following the Labor ShortageInitiative, which ended in 1994. The WEP still directs a number of such projects.
4. See Kathryn C. Cauble, Judith D. Burnette, and S. Suzanne Roche, "Distance Learningin Retrospect," Bunker Hill Community College, March 1997, and Christine Hayes-Sokolove, "Medical Radiography Internship," in Andrés Torres, *The Worker Education Program (WEP): A Summative Evaluation* (Boston: University of Massachusetts, Center for Labor Research, 1994).
5. The distribution of program activity was as follows: 1991, 9 courses at 8 sites, 134 participants; 1992, 12 courses at 7 sites, 248 participants; 1993, 28 courses at 8 sites, 442 participants. The total of 824 participants represents enrollments, not individuals. Data were not available at time of writing to verify how many different persons participated, but our estimate based on program records is that about 400 workers took courses. This figure does not include the eleven interns who completed the intensive medical radiography component. College preparatory–level courses included precollege English 1 and 2, precollege math 1 and 2. College-level courses included English, math, medical terminology, biology, anatomy, introduction to micro-computers, introduction to health services, and computer skills.
6. Harneen Chernow, "The WEP Experience: A Practitioner's Perspective," unpublished paper, December 1994.
7. As with the union, college administration had undergone a change during the period between the WEP proposal development and implementation. Liaison responsibility was assigned to personnel who had not been involved in the planning process prior to DMSacceptance of the WEP proposal.
8. Assessments were revived in Cycle 5, 1993, with the entry of a new community college in western Massachusetts, which insisted on using standard testing.
9. Not until Year 3 would a better balance be reestablished between the needs of the two labor sectors: twenty-one courses were offered at the college level, eight at the precollege level.
10. Analysis of Year 3 activities is less comprehensive than for Years 1 and 2. There was no survey conducted of WEP participants, except for the eleven students involved in the internship component. The results of that survey are discussed in a separate report covering the medical radiography program. The bulk of evaluation activities during 1993 focused on separate studies relating to non-WEP topics: a

description of employee training programs in Boston teaching hospitals, a study of black and Latina health care workers, and interviews of students in a traditional allied health careers program at Bunker Hill Community College. The original evaluation plan, supported by the Ford Foundation, was designed to conduct a 1991–1992 two-year evaluation study of WEP.

11. Interviews were conducted with Cycle 1, 2, and 3 participants and others involved in WEP courses through June 1992. For complete results, see Torres, *The Worker Edtion Program*. A total of 380 hospital employees were reached by phone, of whom 202 were enrolled in WEP courses; 152 of these successfully completed their course(s). Not all participants were available to be interviewed.
12. In the first three cycles, 380 persons expressed interest in WEP, of whom 178 (47%) were not enrolled because they either voluntarily withdrew from the application process or were not accepted by the program. Separate records, maintained by WEP, indicate that the ratio of nonparticipants to total inquiries was slightly higher for Cycle 4 in Year 2.
13. See, for example, William A. Darity, *Labor Economics: Modern Views* (Boston: Kluwer- Nijhoff, 1984), and Susan F. Feiner, ed., *Race and Gender in the American Economy* (Englewood Cliffs, N.J.: Prentice-Hall, 1994).
14. Overall, the apparently low representation of minorities among WEP participants reflects the low numbers of these workers among Tier 1 and Tier 2 workers in the seven suburban hospitals where the majority of courses — 16 of 21 — were given during 1991–1992. For example, reports from the Federal Equal Employment Opportunity Commission, "EEO-1 Report," supplied by participating hospitals, indicate that about 6 percent of Tier 1 and Tier 2 employees in the seven suburban hospitals are African- American, Hispanic, Asian, or Native American.
15. This includes income from *all* members of the household. In the early 1990s the poverty level for a family of four was set at about $16,000, so one-quarter of WEP families were barely beyond this threshold.
16. About 30 percent have had some exposure to college in addition to their participation in WEP; less than 7 percent have completed college. The average WEP student's parents have less education than a high school degree (eleven years of schooling for mother and father).
17. Most of these committees were built on previously existing entities. WEP helped to expand their range of activities to include workplace training programs.
18. Department of Medical Security, Commonwealth of Massachusetts, *Labor Shortage Initiative Education and Training Summary: Round One and Round Two* (Boston: Department of Medical Security, 1993). These figures refer to all persons serviced, including those who were not enrolled in a program. They also cover a wide range of program models and curricular content.
19. Note that three hospitals already had a Career Ladders Program.
20. This discussion refers primarily to Local 285. In the case of Local 767, which had been operating a Career Ladder Program with its hospitals since the early 1980s, WEP was an addition to an existing configuration of training programs.
21. Personal interview, June 10, 1992.
22. Alan Sager and Deborah Socolar, "Imprudent and Impatient: Are Hospitals Closing Too Fast?" *Boston Globe*, April 27, 1997, E1.
23. The original WEP model, which was funded through the Labor Shortage Initiative, ceased to operate in 1995. It is important to note, however, that WEP continues to operate a range of education programs for Local 284 of the Service Employees International Union.

Distance Learning in Retrospect

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This article describes the design and implementation of a long-term education project, a joint effort of the Service Employees International Union, Bunker Hill Community College, and nine Massachusetts community hospitals. The object was to offer an associate degree in medical radiography to eleven participants. Details of the funding source, admission process, curriculum, student support services, quality assurance, and problems and solutions are outlined. The authors offer recommendations for future replication.

History

In 1990 the commonwealth of Massachusetts instituted the Department of Medical Security (DMS) to oversee moneys of the DMS Labor Shortage Trust Fund, which was created by assessment of a fee of one-tenth of one percent of revenues on all acute-care hospitals. The purpose was to provide financial support for health care initiatives in areas of labor shortage at a time when several professions were deemed to be seriously underrepresented, among them nursing, radiology, and respiratory and physical therapy.

Service Employees International Union (SEIU) Local 285 presented a proposal that would benefit its members in entry-level, low-paying hospital jobs and train a group of qualified SEIU employees in one of the identified shortage areas. To fulfill its goals, the union formed alliances with nine hospitals throughout the commonwealth and with Bunker Hill Community College (BHCC) in Boston. The institutions, and their distance from BHCC, which would either provide or coordinate the educational offerings, were Burbank (in Fitchburg, 50 miles), Boston City (5 miles), Cape Cod (in Hyannis, 60 miles), Falmouth (84 miles), Framingham (12 miles), Hale (in Haverhill, 32 miles), Hillcrest (in Pittsfield, 160 miles), Jordan (in Plymouth, 45 miles), and North Adams Regional (148 miles). BHCC offered both a regular full-time and an innovative part-time evening medical radiography option, which provided students with jobs and an

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opportunity to acquire new skills. SEIU was awarded a three-year grant of $250,000 to begin in January 1991. The member hospitals determined that the grant would finance the free medical radiography program, which would be offered statewide.

The original proposal included a fiber-optic system that would have allowed the didactic materials to be sent to all the hospitals, but DMS considered its inclusion excessively extravagant and requested a revised budget.[1] To comply, one of the authors single-handedly discarded the fiber-optic portion, thereby leaving the educational plan in place without the means to implement it with appropriate, up-to-date technology. However, the grant had been awarded, the money was in hand, and the majority of the players set out to activate this ambitious project.

To further complicate the issue, the committee that initiated the plan modeled it after an apprenticeship program in which participants become immersed in the practical setting, thereafter receiving related coursework as necessary. Because this approach did not meet national accreditation standards, BHCC staff were unwilling to consider it. They said the proposed model was an unacceptable education plan, one that had been used years previously when medical radiography programs were housed in hospitals and operated paternalistically, employing students as staff rather than as active learners. It was essential that the new program be credible, coordinated, and meet all national accreditation standards.

Because the funding was limited to a single three-year period, it was necessary to resolve the issues quickly. A clearly worded statement of the college's accreditation requirements was offered. In discussions with all those involved, it became obvious that students would gain competency through the hands-on aspect. This would be accomplished by starting the program on a part-time basis, offering a foundation of instructive material that would be integrated into the clinical experiences. In addition, testing demonstrated that all the interns had to learn basic mathematics before tackling the program's college-level algebra requirement. Students were encouraged to take the basic coursework at a college or university nearest their place of employment or residence. A few interns had acquired transferable credits, but the majority had to begin at square one. The curriculum committee prepared individual educational plans. Classes had been provided and credit obtained through transfer, external studies, and contract and on-site delivery.[2]

The endeavor to educate students at several different sites presented staff with demanding and time-consuming tasks, including training participants on site to be clinical educators and adjunct faculty. At the same time, they had to conduct the program and maintain quality to ensure that students at a distance completed the program and passed the registry examination. Clinical instructors drawn from hospital staff were offered orientation and follow-up workshops concerning the issues and the supervision of students. All new clinical sites were approved, and two Boston medical centers were included in the distance-learning experiences.

Admission

The students selected by the SEIU for the latest option came from various academic backgrounds. The union had to determine their acceptability in terms of their longevity and union standing and whether they met the college prerequisites. This was difficult because some students were at the developmental level — two who were selected were not eligible to start for that reason and took about a year to attain the necessary level for

acceptance to the program — while others had already earned college credits. All students were notified that they must maintain a B average in all radiation science (RSR) courses and a C in general college courses to meet the stated program requirements. Students had to be high school graduates or the equivalent, have taken a biological science with laboratory work, and test into college algebra (MAT 195). All college entrants had to take a computerized placement test, which measured their ability in mathematics, English, and reading. Students placed in developmental courses had to complete all required coursework before being accepted into the program.

Eleven interns were chosen on the basis of their ability, longevity, and employment status. There ensued discussions as to the most effective method for offering the program. Consultation with medical radiography faculty led to fashioning the distance option, as it came to be known, after an existing successful part-time evening program (see Exhibit 1).

Curriculum

An initial review of the curriculum determined that the distance students, like all Bunker Hill Community College students, would be required to pass practical examinations for the first two positioning courses, RSR 106, Essentials of Positioning 1, and RSR 107, Essentials of Positioning 2. The integration of distance and on-site medical radiography students accomplished the following:

- maintained quality assurance;
- improved the sense of belonging among the distance students; and
- increased communication between distance and college-based faculty.

BHCC assembled a team to adapt the medical radiography curriculum for SEIU distance learning. Members included the dean of Health Care Professions, Medical Radiography Program faculty, Center for Self-directed Learning staff, academic instructors, and clinical site coordinators. Their first challenge was to assess and design an individualized education plan for each intern. Students fell into three groups: three had fulfilled many mathematics, science, and English requirements; six were ready to undertake college-level mathematics and English and were already taking science courses at other institutions; and two had to complete developmental courses prior to being admitted to college-level courses.

The second challenge was to examine the program courses and decide how each could be adapted to distance-learning modalities.[3] Basing them on existing BHCC models, the committee tailored some courses to the requirements of the External Studies Program of the Center for Self-directed Studies. Other courses were devised as individual contracts, a format that allows instructors to break subjects down to distinct modules. Students must meet with instructors at scheduled times for review and assessment within a two-semester time frame to fulfill the requirements. The committee also surveyed courses offered by other institutions that would enable students to take classes nearer to their homes. For courses outside these formats, students had to travel to BHCC on a specific schedule. For example, six-hour sessions of Physics 1 and Physics 2 were scheduled every other weekend.

The third challenge was to examine the sequence of medical radiography course offerings and, using that framework, design an individual educational plan for each

Exhibit 1

Model Curriculum

Year 1

First Semester	Credits
Standards of Patient Care	4
College Writing 1	1
Mathematics	3
Total	10
Second Semester	
College Writing 2	3
Radiation Physics 1	3
Imaging Methods 1	3
Total	9
Summer Semester	
Radiation Physics 2	3
Behavior or Social Science elective	3
Total	6

Year 2

Third Semester	Credits
Imaging Methods 2	3
Anatomy and Physiology with Laboratory 1	4
Total	7
Fourth Semester	
Anatomy and Physiology with Laboratory 2	4
Essentials of Positioning 1	3
Clinical Internship 1	2
Total	9
Summer Intersession	
Health and Disease	2
Essentials of Positioning 2	3
Clinical Internship 2	1
Total	6

Year 3

First Semester	Credits
Essentials of Positioning	2
Radiology Biology and Protection	3
Clinical Internship 3	1
Total	6
Second Semester	
Practicum 1	2
Practicum 2	2
Total	4
Summer Semester	
Practicum 3	3
Practicum 4	3
Total	6
Total Credits	63

intern. Countless hours were spent analyzing the program of study sequence and exploring the feasibility of offering courses out of sequence. The committee considered factors including the educational impact on the program, the availability of qualified instructors, and each intern's work schedule. Once the plans were drawn up, it was time to inaugurate the first semester, which was accomplished in September 1991. A typical plan comprised contract courses, courses at nearby institutions, and an external studies course.

Because of their proximity to the college, the three Boston City Hospital interns attended classes with the regular medical radiography students.

As the first semester progressed, students began to show evidence of distress. Some had difficulty keeping up with the work schedule, and delays in sending and receiving materials through the mail were frustrating for all. Students who were not used to studying on their own had to learn to manage their time. It became necessary to identify a contact person at each participating hospital who could administer tests and assess the students' academic progress. They worked closely with the college site coordinator to monitor and recognize the discrete needs of each student.

By the spring 1992 semester, the individual plans of each intern had to be reviewed and updated to provide the basis for documenting each student's progress and fulfilling needs for the following semester, including scheduling times and locations of courses as well as purchasing and mailing books and materials. In addition, the SEIU director and hospital management had to negotiate work release time for students on the basis of their individual education plans, a time-consuming and often frustrating process. Factors such as failure of students to complete a course on time disrupted plans and presented scheduling problems.

Student Support

Another challenge for the BHCC team was to provide telephone and on-site support and encouragement as well as academic guidance to the distance-learning SEIU interns, who reported their work schedules and indicated the best times they could be reached at work and at home. Initially, it was difficult to establish the lines of communication, and interns discovered that they had to keep in touch with many people for different reasons. The main task of the BHCC site coordinator was to keep track of each intern's academic progress and needs.[4] It involved ordering books and materials from the bookstore and ensuring that they were mailed to the appropriate recipients. Telephone conversations ranged from inquiries concerning interns' progress with course materials to dealing with work release schedules and personal problems. Such calls were usually placed during evening hours when interns were apt to be home and have the time to discuss pertinent subjects.

The interns, who met as a group for orientation at the beginning of the program, were required, at least once a semester, to present themselves at the college for additional information and update sessions. Aside from such contacts, most counsel and support was offered via telephone and on-site visits by the coordinator and instructors. The site coordinator's responsibilities left little time for arranging schedules and telephone calls, and the scarcity of long-distance lines presented a drawback. It was difficult to anticipate students' needs for this new venture, and the mundane tasks of mailing books to students, making sure interns were returning material to the appropriate college departments, and collecting medical forms consumed large amounts of time.

Quality Assurance

All U.S. accredited radiography technology programs are governed by the Joint Review Committee on Education in Radiologic Technology (JRCERT). To retain accreditation, each program must follow specific guidelines. JRCERT monitors each program every

five years or sooner, depending on the program's previous review. Quality assurance is maintained by assessing a provider's curriculum, faculty, clinical affiliates, and personnel. When SEIU approached Bunker Hill Community College, its Medical Radiography Program was accredited for two options, full-time day and part-time evening. Distance learning became the third. The two-year, full-time program includes integrated classroom, laboratory, and clinical components; the nine-semester, part-time evening program clusters the instruction in a five-semester schedule followed by four semesters of clinical experience.

There was concern as to how JRCERT might view the decision to model the distance option on the part-time program. The major difference between the two was that the distance option negotiated release time for students to attend class and clinical portions of the curriculum. Prior to the agency's next scheduled visit, an outside consultant was hired to review the program from the perspective of JRCERT standards. It was felt that the consultant, who was not associated with the college or its program, would be more objective than an insider. He reported that the program met all the accreditation guidelines but that it would be difficult to explain how the three different approaches produced the same results. To meet such resistance, the faculty designed, as an introduction to the accreditation team's visit, a multimedia presentation that clearly compared and contrasted the similarities and dissimilarities of the three options, Additionally, clinical affiliates provided a realistic setting for the students' clinical experiences. The college was responsible for obtaining signed contracts that clarified the hospital/college role and verified the partnership.

The distance option was also evaluated by SEIU and the Ford Foundation. The latter, considering countrywide duplication, monitored the program from its beginning. SEIU monitoring was required by the grant.

Problems

Several problems had to be addressed during the life of the grant: appointing and training on-site clinical instructors, Committee on Allied Health Education and Accreditation's approval of the new clinical sites, effective communication among all participants, and meeting the multiple needs of students, staff, faculty, and hospitals.[5]

Communication seemed to be the most difficult issue, but we implemented a number of methods that provided clear and direct interactions, including the designation of a liaison at each site. That person received, monitored, and returned all course material, namely, tests, forms, and evaluations. The college counselor telephoned each intern weekly, at a set time and place, to keep abreast of progress and concerns.[6] Each student received a list of titles, addresses, and phone numbers and the role and responsibilities of all persons involved in the project to facilitate direct contact with an appropriate person when questions arose. College faculty, who had to increase the frequency of their visits to the clinical sites, were able to offer personal direction and suggestions to those who sought advice.

Much resistance emerged, one of the greatest obstacles being to convince full-time medical radiography faculty to participate. Their apprehension was expressed in such questions as Where do I find time to add more work to my schedule? With whom will I confer about distance teaching since this is the first such offering in the state? What type of compensation will I receive? How will this project affect program outcomes? College on-site clinical personnel were concerned that the new distance clinical

instructors would not be easily integrated because they lacked experience and knowledge of the program. The clinical instructors at participating hospitals had little or no exper-ience as educators. All of this meant that individual training and instruction would be essential to ensure successful course presentation. One approach was to utilize audio-conferencing, as Henry suggested.[7] The faculty and support staff met monthly with the division dean to manage coordination of students and faculty, which kept the program on track.[8]

The faculty at distant sites kept in close contact with the on-site faculty, usually weekly, via telephone. Such communication concerned course materials, student grading, and requests for assistance with the clinical evaluation tool. Formal meetings were held with participating hospital personnel, who were invited to meet at the college, giving them an opportunity to interact and better understand the concept and direction of the program and this particular project. Faculty and staff orientation was accomplished through a series of workshops designed to

- enhance this mode of education;
- offer the faculty the opportunity to become familiar with individual styles of the college staff;
- establish the concept of the team approach; and
- encourage a sense of collegiality.

Once the program was set in motion, the coordination improved tremendously. Major components included

- continual assessment and evaluation;
- active participation by the distance students;
- in-depth examination of clinical competencies; and
- constant fax use.

Recommendations

We offer several recommendations resulting from our intimate connection with the program during the years of the grant.

- Incorporate the necessary fiber-optic technology.[9]
- Involve college personnel in the initial selection of student interns.
- Employ two persons at the college to deal with students exclusively, to counsel, register, communicate, administer, and visit, and direct all curriculum efforts and initiatives in close coordination with project and college personnel.
- Purchase additional instructional aids for the new clinical sites.
- Allow students to "own" more of the project, that is, by requiring them to pay a nominal fee each semester to help defray total project costs.

- Most important: replicate this program statewide, using appropriate technology, with another group of interns.

Fulmer et al. note that "people are the key to success in distance learning. These include motivated students, full- or part-time faculty at outreach sites for clinical supervision and liaison, flexible on-campus faculty."[10] Our experience has certainly validated this statement.

Update

Ten of the eleven students enrolled in the program graduated and are registered technologists working in the field.

The manuscript for this article was formatted and Exhibit 1 created by Nancy K. Pitchford.

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Performance and Accountability in Human Services

Ownership and Responsibility of Professionals

Anna-Marie Madison

The recent frenzy of grant makers and government agencies in requiring impact evaluations of all grant recipients has created consternation among human service providers. To ensure their agencies' survival and worker job security, the leaders are faced with meeting the demands of funder-driven programming. Agencies seeking funding must comply with funder-defined needs and accountability criteria rather than their public missions. This article describes the use of mission-based performance evaluation rather than funder compliance to demonstrate accountability for mission accomplishment.

Within the business, public, and nonprofit sectors, no topic has been discussed more in the past five years than performance and accountability. The chain of events leading to this attention began with many American companies' loss of market share to foreign competitors. This realization led to the rise of total quality management and other management concepts as means to increase American companies' quality of performance.[1]

With the release of the 1993 *Report of the National Performance Review* and the passage of the Government Performance and Results Act of 1993, performance measurement and accountability became management tools in the federal government. Several of the more progressive states have taken the lead in implementing performance reviews at the state level. The International City Managers Association is working with cities to design performance measures at the local level. United Way, one of the largest sponsors of nonprofit agencies, has initiated a major nationwide effort to introduce its agencies to the logic model of result-oriented programming and performance evaluation.

The proliferation of interest in performance and accountability is accompanied by numerous unresolved problems. Some of the questions most frequently raised are: Who defines performance? To whom is the organization accountable? and How should performance evaluation be used? In the human services, with its multiple constituents and imprecise measures of outcomes, there is a high degree of consternation and trepidation

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about the intent and possible consequences of performance evaluations.[2] Many organizations fear that performance evaluation will be used to penalize them if their performance does not meet the stakeholders' expectations. Such fears are reinforced by uncertainty concerning the future of human service funding.

A major reason for apprehension among human service providers is that evaluation, requested by program sponsors, is externally controlled. Providers funded by multiple sources might be asked to conduct impact evaluations for each sponsor, but receive no increase in financial support. Agencies are forced to use funds from their operating budgets to hire outside evaluators. Ordinarily, for the amount of money available to them, human service providers cannot hire an experienced, competent evaluator. Consequently, they hire people who, in most cases, know less about evaluation than they themselves do. The quality of the evaluations is poor, offering scanty useful information for the service providers.

From the human service worker's point of view, evaluation is used as a tool for political expediency rather than for furnishing useful feedback on improving service delivery. This means that providers are literally held hostage to funders' definitions of performance and accountability. To ensure their agencies' survival and workers' job security, leaders are willing to relinquish ownership of their responsibility to shape the future of human services. The question most frequently raised by human service providers is: How can we reclaim ownership of shaping and guiding activities to achieve the organization's mission, rather than responding to external controls?[3]

If they are to use evaluation as a tool to guide agencies in strategic decision making about their future, human service professionals must reclaim ownership of performance and accept responsibility for results in accordance with the mission of the organization. The first step is to take control of the process. Because providers are responsible for accomplishing their agency's mission, they must determine how to recognize progress. The standards they set for themselves must be challenging, but achievable. The measurement criteria should allow the providers to realize when things are not going well, to determine what changes must be made, and to decide how to make them.

I present a mission-focused evaluation strategy, one which illustrates how service providers can use evaluation to demonstrate accountability and improve performance. I use action research and participatory evaluation theory to explain the role of human service professionals in a community of inquiry in which the mission of the organization is the focus of evaluation. Finally, I offer suggestions for graduate education in human service management to prepare professionals to meet the requirements for assuming ownership of performance and taking responsibility for results.

Mission, Performance, and Accountability

The first step for professionals in taking control of evaluation is to change the focus of evaluation so that it reflects agency accomplishment and accountability based on agency-generated criteria. It is important to replace the compliance-based model of accountability, which emphasizes program activities and outputs rather than impacts. Compliance-based evaluations tend to address questions related to adherence to rules and regulations, measurement of agreed-upon outputs, and efficiency measures of output units per resource expended.[4] Less likely to demonstrate the quality of the services provided and the impact of the service on the community, compliance-based evaluations are not clearly

distinguishable from performance audits that evolve from accounting and financial auditing traditions.[5] The weakness in these evaluations is their representing an accounting process rather than demonstrating accountability. An alternative to compliance-based accountability is mission-based performance accountability.

The mission-based approach to demonstrating accountability incorporates the concepts of performance-based accountability, which emphasizes results, [6] and mission-based accountability, which focuses on the context of the mission and the results of the intervention relative to the mission of the organization.[7] Accountability is determined when the organization has demonstrated responsiveness to its public mission.[8]

Evaluation of program success should demonstrate the impact of the services delivered on the accomplishment of the mission, with rewards distributed according to the results that advance the goal. Mission-based performance accountability allows an organization to demonstrate progress toward a predetermined purpose, to establish a baseline to measure achievement attainment of the purpose, and to make adjustments to increase the efficacy of the intervention.

For example, the mission of a nonprofit, community-based agency serving youth might be "to end the neglect of youth in our community by providing consistent, supportive, caring adult guidance so that youth can make a successful transformation from adolescence to adulthood and reach adulthood equipped to achieve successful adult lives." This statement outlines the problem, the need to be addressed, the target population, and the ultimate goals. The *problem* is the neglect of youth, which might include lack of adult involvement in their lives and of community-based services that provide constructive activities to engage the creative energies of adolescents. The *need* is to provide such activities, under the supervision of supportive, caring adults, to focus the interest of youth. The *target population* is youth between the ages of ten and eighteen. The *ultimate goal* is to equip youngsters to achieve successful adult lives.

To examine the mission, an arts intervention program provides community-based support to youth through the integration of traditional social services and cultural arts programming. In a safe environment, youth receive the nurturing, protection, and guidance essential to developing social competence, self-confidence, and positive attitudes about their futures. The delivery system provides opportunities for creative expression and the exploration of personal skills and abilities that are critical to the adolescent stage of human development.

The focus of the program evaluation is on growth toward the ultimate goal rather than absolute success or failure. Effort is channeled through a logical hierarchy of results arranged so that the achievement of the lower goals leads automatically to the achievement of the higher ones. Thus, the efforts are aligned toward the common purpose of accomplishing the mission of the organization.[9] Exhibit 1 details the youth program hierarchy of goals.

If during the first year only Goal 1 is achieved, the agency is not considered to be a failure. Likewise, if a youth enters the program at age ten, the degree to which the ultimate Goal 6 is approached cannot be determined until the individual reaches adulthood. However, completion of Goals 2, 3, 4, and 5 is essential to attainment of Goal 6.

A major advantage of mission-based performance accountability is its design to improve performance rather than to penalize poor performance, the aim being at higher performance toward the fulfillment of the mission. Even with poor performance, mission-based accountability has the potential to create pressure on improvement of poor performers.[10] High-performing human service agencies seek to retain their positions as leaders, and low performers seek to improve their standing in the community of providers.

Exhibit 1

Youth Program Hierarchy of Goals

Goal 1	To create a safe environment to engage youth in constructive activities under the supervision of supportive, caring adults
Goal 2	To provide a range of cultural arts activities that allow creative expression and social and psychological development and growth
Goal 3	To effect change in the perceptions and attitudes of youth
Goal 4	To effect change in the behaviors of youth
Goal 5	To effect the successful transformation from adolescence to adulthood
Goal 6	To effect the achievement of a successful adult life

Mission-based evaluation is compatible with the dynamic nature of human services, which deal with open-ended and ever-changing complex human conditions. Success in most cases depends on many micro- and macroenvironmental factors beyond the control of the providers. Human service organizations must constantly adapt to change created by the turbulent environment in which they exist. Therefore, to increase outcomes, there must be opportunities to monitor performance and to make changes at various intervals. Mission-based performance evaluation allows this to occur.

It also clarifies the question: To whom is the organizationa acountable? Accountability implies two elements involved, "those giving account" and "those holding to account."[11] The problem for human service providers is the diversity of those holding to account. To demonstrate accountability, providers feel that they must furnish visible executions that satisfy sponsors, the communities they serve, and the public at large, the last of whom want to know if their tax dollars have any impact on the defined problems. Clients, also members of the public at large, are concerned about the quality of and the degree to which the services match their needs. Public officials and philanthropic sponsors are concerned about the cost-effectiveness and cost-benefits of services.

The definition of accountability as responsiveness to the public mission allows an organization to circumvent some of the problems inherent in the demonstration of responsibility to multiple constituencies. First, this definition confines accountability to the parameters delineated in the mission. Second, measurement indicators must assess the impact of the intervention toward accomplishment of the mission. This allows human service professionals to challenge performance measurement criteria that are not germane to the discharge of the mission. Even cost-effective and cost-benefit evaluation questions must be framed within the context of the mission.

When combined with strategic planning, mission-based performance evaluation strengthens accountability.[12] The strategic plan provides the opportunity to demonstrate accountability based on the relationship between mission, strategic input resources, strategic actions, and performance results. Providers are able to isolate input factors that contribute to overall mission accomplishment, such as lack of strategic resources to implement the plan. This information is useful as feedback to adjust funding, which can improve the overall results of action. The match between inputs and results can demonstrate productivity even though progress toward the ultimate mission is slow.

Performance monitoring of strategic actions also provides feedback regarding achievability of the mission. For example, the public mission of the Massachusetts Department of Human Services is "to end poverty among women and children by providing educational and job training opportunities and social supports to women so that they can obtain employment that provides them and their children economic independence." In this case, the indicator of success is the number of poor women who become economically independent. The number of women participants in the program and the types and quality of activities provided, while inappropriate measures of impact, can demonstrate the relationship between input resources, strategic actions, and probable results. Performance monitoring detects the adequacy of resources and whether the service delivery system is capable of producing the desired results. If it is determined that the training offered will not lead to good-paying jobs or that less than full provision of funds for tuition and fees will prevent women from attending college, one can assume that the ultimate goal of financial independence is probably unreachable.

Even though strategic planning and mission-based performance evaluation are power tools to demonstrate accountability, there are limitations to their utility. Service providers must be cognizant that demonstrating accountability for a public mission does not guarantee that an agency will receive broad-based public support. Those who oppose the intent of the mission in most cases do not approve of it for ideological and political reasons. Therefore, evaluation should be for the purpose of accomplishing a mission, and gaining support for it should be left to the political process. This is not to contend that efforts should not be made to secure support but that evaluation is not the best vehicle for changing political ideological stances. For this reason, demonstration of accountability should be targeted to supporters of the public mission.

Action Research and Human Service Professionals as Participants

It is advocated that human service providers be primary participants in the mission-based performance evaluation process. Action research theory, which provides a useful framework for examining the role of human service professionals in evaluation, is based on the notion that agents design action to achieve intended consequences and monitor themselves to learn whether their actions are effective.[13] One goal of action research is to engage the community of practice in becoming active participants in inquiry about the consequences of its actions. This approach to inquiry differs from traditional evaluation methods in that a human service professional is both the agent of and a participant in judging the results of action. The concept of practitioner as inquirer calls for the professional to assume the ownership of defining how actions are to be assessed and to share responsibility for evaluation with other stakeholders.

Participatory evaluation provides a conceptual framework for examining the roles of the various participants in the evaluation process, postulating that human service clients, professionals, and professional evaluators be included in the evaluation process.[14] Through their intersecting roles they form a partnership to promote learning for action and change. Within this community the evaluation specialist's role varies according to the needs of the human service professionals. The evaluator may be an advocate, a coach, a facilitator, a trainer, or a technical adviser. Together the clients, professionals, and the evaluator shape the questions, establish measurement indicators and the rules of inquiry, identify data sources and collection methods, collect and analyze data, and interpret the meaning of findings.

The first step in creating a community of inquiry is to create a risk-free environment in which trust can be built. To that end professionals, the communities they serve, program sponsors, and evaluators must establish core values concerning the role of evaluation, which become the building blocks for developing a trust relationship. In this community the human service professional must take ownership of the delivery effort and the success or failure of strategic actions. Ownership requires that this professional be given the authority to decide how to accomplish the agency mission and the responsibility for achieving results. Accountability is determined by performance, as measured by indicators of success toward the accomplishment of the mission, and the indicators of success are established by the community of inquiry.

The questions most often raised are: How should performance be measured, who should define the measures of performance, and whose interpretation of the results should prevail? Performance questions concern the way reality will be constructed, which relates to observation methods and requirements for the validation of reality. Questions about defining the measures of success concern whether the persons most affected by the program (clients), service providers (human service professionals), or the expert evaluation authorities (evaluators) should establish the measurement indicators. Questions concerning interpretation of findings relate to competence in understanding their meaning within the context of completion of an organization's mission. Forming the community of inquiry eliminates potential tensions among them by inclusion of all three groups, each of which has valuable competencies in establishing valid performance measures.

The client contributes the validity of personal experience and the legitimacy of contextual definitions of reality in the discovery of truth,[15] input that provides an understanding of the consequences of actions on the lives of the targeted population. The client's perspective is critical to determining the need for adjustments in program actions or the mission of the organization. The clients furnish an opportunity for the providers to reconcile the difference between the intended and the real consequences of actions.

For determining measurement indicators, human service providers contribute their technical competency in understanding the actions taken to achieve the mission. They are the most competent to define performance results in the context of the intent of the mission and to explain actions in the context of the community of practice. However, agency actions in pursuit of its mission cannot be viewed in isolation from the values, beliefs, and interpretations of the community of practice.

A major contribution of the evaluation specialist is bridging the gap between practice and theory, whose constructs are based on the realities of the clients, and the providers are useful in explaining actions. These all allow observations of phenomena to identify the sequence of actions that lead to a particular result. The theoretical construct helps to link causal assumptions, intervention strategies, implementation actions, and impact outcomes, a process that helps to clarify the mission and determine whether the desired results are realized.

A major value tension in evaluation arises in choosing the methods appropriate to explaining the effects of human service interventions. The focus of the evaluation questions determines the observation methods and the requirements for the validation of reality. The most likely source for the validation of the consequences of interventions to individuals is the client. The most acceptable approach to capturing the essence of a client's experience is through qualitative methods. Providers are most likely to produce

baseline information concerning the conditions prior to intervention, performance monitoring data regarding the service delivery process and outputs, and data concerning the changes brought about by the intervention. These data are most apt to be quantitative. For example, if community norms are used to verify change, quantitative data are more likely to be prepared by the providers. Therefore, descriptive and explanatory measurement indicators are used to validate reality in the discovery of truth. Similarly, both the clients' and the providers' constructions of reality are included in the interpretation of achievements directed toward the mission of the organization.

Add Evaluation to Human Service Management Graduate Programs

The trend toward result-oriented programming and performance evaluation has implications for graduate education in human service. Professionals in that field should have the technical skills to identify the strategic options available to them to consummate an agency's mission. They must be able to define and plan operations for performance measurement criteria to monitor the ongoing programs and to assess the performance directed toward the success of a mission. Therefore, graduate education in human services management should include performance monitoring and evaluation in the academic core.

Such courses should be designed to develop proficiency in the application of analytic techniques to establish realistic, measurable performance indicators and measurement criteria for the assessment of overall results. Suggestions for course content and sequencing to develop these skills are offered in Exhibit 2.

The human service management curriculum should present evaluation as both a feedback and a feedforward tool to improve performance. To this end, the curriculum should be arranged in a progression linking strategic planning, performance monitoring and evaluation, and resource allocation decision making. This configuration would attach performance monitoring to the development, monitoring, and assessment of the strategic plan. Evaluation as a feedback tool defines the results of actions taken to bring a mission to fruition, and it is a feedforward tool for planning. Integration of the three elements to form a comprehensive body of knowledge and skill development presents a systematic approach to the planning, implementation, monitoring, and evaluation of the public mission of programs.

Technical skills in these three subjects should be merged with behavioral knowledge concerning the political and organizational context of evaluation.[16] Inclusion of the political dimension in teaching evaluation does not suggest that managers become politicians, but it requires that they understand and incorporate the affect of public policy and other political dimensions when establishing a mission, goals, and objectives and in explanations for the result as they relate to the mission. Particularly in public agencies, it is essential that human service professionals also understand and explain the affect of public policy and organizational issue tensions on attaining a mission.

It is important for human service professionals to assume ownership of the process so that evaluation has meaning beyond the political agendas of the sponsoring agencies. Mission-based performance evaluation, which establishes boundaries for determining accountability and allows the human service professionals to define the measures by which they are to be judged, is the best method for demonstrating accountability.

Exhibit 2

Strategic Planning, Performance Monitoring, and Evaluation Content and Sequencing

Research Methods: Research methods and techniques relevant to human service management, including the logic of design, measurement, data collection, processing, and analysis. The focus should be on the application of a systematic approach to investigation and problem solving.

Strategic Planning for Public and Nonprofit Organizations: The strategic planning process as a systemic approach to identifying and resolving issues through the assessment of the environment inside and outside the organization. The focus should be on strategic planning for the purpose of making strategic decisions that shape and guide an organization's activities.

Performance Monitoring: Principles and techniques of performance monitoring to track the implementation of the strategic plan and to provide feedback to improve implementation. Focus should be on principles and methods for determining reliable, valid measurement indicators of performance, the appropriate intervals to measure performance, and designing information systems for the collection and retrieval of performance data.

Outcome Evaluation: The application of research methods to the evaluation of human service programs. Topics include evaluation design, measurement indicators of success, data collection requirements, and data analysis, presentation, and reporting. Focus should be on service delivery outputs, impact, and cost-effective evaluations.

It places them in a definitive position when they are confronted with externa judgments about performance and accountability. Service providers can release themselves from the grips of external control. Rather than being funding-driven, agencies are able to shape service delivery in the best interests of their clients and of the communities they serve. The fear and threat of accountability to their funders rather than to their communities abate when agencies seek funding that supports their mission and are held responsible for its accomplishment.

Because most human service professionals have little or no training in evaluation, it is essential for their graduate education in management to include the development of competency in the analytical skills required to monitor practices undertaken to complete missions and to assess the overall effects of aggregate actions.

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The Potential Impact of Workforce Development Legislation on CBOs

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The proposed congressional legislation revamping the employment and training system will result in budget cuts, program consolidation, and block grants for the states. These changes are potentially harmful to community-based organizations (CBOs) because (1) they eliminate categorical funding that traditionally has required contracting with organizations which specialize in servicing the disadvantaged, and (2) they introduce stricter performance standards that may be unattainable for many small-scale operations. However, the adoption of best practices in serving non-English-speaking and poor populations, increasing connections to emerging government intermediaries in labor markets, and establishing greater linkages to postsecondary educational institutions may offer CBOs the opportunity to strengthen their position within the employment and training system. Community-based organizations have a great advantage over other organizations because they have the expertise that is necessary for the emerging training system to succeed, namely their experience in serving disadvantaged populations.

After more than two years of debates, closed-door negotiations, and a tremendous lobbying effort by key players, Congress may finally be approaching a resolution to the contending proposals revamping the employment and training system. As is generally the case with recently enacted or pending block-grant legislation, the new legislation is likely to cut funding in exchange for greater flexibility at the state and local levels. An important component of the restructuring of the employment training system is the centralization of services in government intermediaries working under the supervision of state and local boards or "partnerships." The devolution of federal training programs poses a question: What impact is congressional reform likely to have on disadvantaged populations? The federal government has historically been more concerned than state and local authorities with protecting the rights of minority and economically

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disadvantaged groups. In particular, services to disadvantaged populations are largely provided by an infrastructure of community-based organizations (CBOs) that may very soon be at risk of disappearing as a major component of the employment and training system.

CBOs, which have traditionally closed the gap in services left open by federally funded training programs, are in great danger of being adversely affected by the new legislation. The potential for budget cuts and the proposed program consolidation will increase competition among service providers and make it more difficult for CBOs to serve populations that require more expensive programs. The new legislation will be particularly hard on programs with relatively small training operations, those serving the needs of non-English-speaking and poor populations, and those lacking strong connections to the institutions that are likely to emerge as the dominant players in the new system.

Despite this grim scenario, a revamped employment and training system offers a unique opportunity for CBOs to strengthen their position. Whether the current provisions of the House or the Senate bill prevail, the new legislation may provide opportunities to strengthen the ties between disadvantaged populations and employers' recruitment networks by promoting employers' participation and ownership of the system and enable CBOs to specialize and focus their services on well-defined segments of the labor force. However, taking advantage of the opportunities offered by the new legislation requires a clear understanding of the policy directions and the relative strengths and assets of CBOs in the implementation process. It is imperative that those which serve the poor and the disadvantaged learn from successful organizations and examples of best practice throughout the country.

My main conclusion is that best-practice cases of community-based employment and training programs indicate a clear strategic direction for CBOs to follow in times of policy turmoil. Strengthening the capacity of CBOs to serve the needs of disadvantaged populations requires greater linkages with school-to-work and one-stop centers; a closer relationship between training programs and industry; and greater integration of community programs with the existing web of community colleges and postsecondary institutions servicing the disadvantaged. Community-based organizations have expertise that the emerging dominant players must have to succeed, namely, experience in serving the disadvantaged. The creation of a new and more effective employment and training system requires the active participation of those most capable of closing the gap between the need of employers and industry for a better-prepared labor force and the training system's ability to develop a workforce from disadvantaged populations.

The second section of this article, which is divided into four sections, presents an overview of the pending legislation and the context for congressional reform of training programs. In many ways, the proposed legislation follows a general pattern of budget cuts, program consolidation, and the devolution of authority from the federal government to state and local authorities that is typical of previous block-grant legislation and current congressional reform. These core elements are present in each version of the pending bills and are expected to be the cornerstone of any new legislation. Despite the differences in the House and Senate versions of the legislation in 1996 and the new versions recently approved by the House and the Senate, it is evident that the new system will be anchored by school-to-work programs for youth and one-stop centers for adults.

On this basis, the third section discusses the key issues affecting the network of CBOs serving disadvantaged populations. These organizations should expect the resulting legislation to limit their eligibility to provide services. The proposed measure favors postsecondary institutions already certified by state authorities and imposes strict performance standards on community-based programs. With the transfer of authority to state and local boards, the mix of services available for contracting to independent vendors will be even more influenced by local politics.

The next section asks, What is the potential impact of legislative reform on CBOs? If it is true that the immediate effect of funding cuts and the change in programmatic priorities may have an adverse effect on the disadvantaged, it is also possible that in the long run services may improve for these people. The impact on them of legislative reform partly depends on the CBOs' response to the new policy regime. The final section examines the strategic responses that CBOs may pursue to take advantage of the changing policy environment.

The Context of Congressional Reform

The revamping of federal employment and training programs is better understood in the broader context of federal policy reform. The three interrelated themes that define a paradigmatic shift in the current wave of new legislation are all embedded within the proposed workforce development block-grant legislation. Most observers have correctly emphasized the public pressure to balance the budget as the dominant force driving current policy debates. Funding cuts to social programs need not have a strong negative effect on services if they are compensated by gains in program efficiency. The impact of budget cuts on services depends largely on the implementation of the new policy directive. The interrelated aspects of block grants and the new federalism are (1) the consolidation and integration of a highly fragmented program and service delivery system; (2) the shifting of authority from the federal government to local authorities; and (3) the introduction of market competition and the increase of private-sector participation wherever possible.

While it is true that these core elements of federal policy reform have evolved from initiatives under the administrations of Richard Nixon and Ronald Reagan to the current form in the pending legislation, this time the proposed changes are significantly deeper in each of the three areas that have defined the trends in federal policy over the past two decades. There seems to be a consensus in Congress, shared by both parties, that there is a need to consolidate programs and establish more coherent social service systems. Such integration can proceed only if local authorities are empowered and have the flexibility to design and monitor programs that are adapted to local conditions. Finally, there is a strong belief among policymakers that the private sector is better prepared than the public sector to understand and react to economic changes. Increased participation by the private sector — whether through housing vouchers, charter schools, or the establishment of intermediary organizations offering technical assistance to small businesses — will result in increased program efficiency.

The proposed new employment and training legislation reflects the major trends in federal policy reform. While most analyses have focused on the differences between the House and Senate job-training bills, the two measures share similar underlying principles. While the differences regarding program implementation are important, the

general areas of agreement are also important. In many ways, community-based organizations and other participants in the current employment and training service delivery system can anticipate the general direction of the proposed legislation.

In 1996, both the House version, the Consolidated and Reformed Education Employment and Rehabilitation System Act (CAREERS), and the Senate version, the Workforce Development Act (WDA), proposed to consolidate almost all existing second-chance education and training programs. Among the most important programs likely to be affected by the new legislation are the Job Training Partnership Act (JTPA), the Perkins Vocational Training Act, the School-to-Work Opportunities Act, the Adult Education Act, the One-Stop Career Centers authorized under the Wagner-Peyser Act, and the Job Corps.

The approved bill, H.R. 1385, Employment, Training, and Literacy Enhancement Act (ETLEA) of 1997, and the bill submitted by the Committee on Labor and Human Resources to the Senate, tend to follow a similar course, except in a few notable areas. In the House bill, the Perkins Vocational Training Act is excluded from the legislation, which alone may explain the increased bipartisan support — it passed by a vote of 343 to 60. The House has already passed overwhelmingly the reauthorization of H.R. 1853, the Carl D. Perkins Vocational-Technical Education Amendments of the 1997 act. However, the contention is far from over. The Senate is considering S. 1186, the Workforce Investment Partnership Act of 1997 (WIPA). This act consolidates vocational education with adult education and vocational rehabilitation in a single bill. To address the disagreement between the education and labor communities, the programs will have separate funding and administration, and no transfer of funds is allowed among the titles. Vocational education advocates contend that subsuming vocational-technical education under job training will cause their programs to be "overshadowed by job training interests and needs."[1] Differences over the consolidation of vocational education and job training could be enough to derail workforce legislation until next year.

The budget cuts originally proposed in the block-grant legislation were substantive. The CAREERS act called for a 20 percent cut from the previous year's appropriation levels, the WDA for 15 percent. The Center for Law and Social Policy estimated that "the actual appropriation for the set of programs affected by this bill is likely to involve spending reductions on the order of 25% to 35%."[2] If these predictions materialize, there is little question that there will be a substantial reduction in funding for which the expected gains in system efficiency, however generously measured, will be unable to compensate, even over a long period of time.

The consolidation of job-training programs and the proposed reduction in funding creates tremendous tension within the existing employment and training system. First, traditional constituencies of each program are in competition. Vocational and adult education programs are administered by the U.S. Department of Education and implemented by local school authorities, while one-stop centers, JTPA, and Job Corps are administered by the U.S. Department of Labor and implemented by a host of service providers, including secondary and postsecondary educational institutions, CBOs, and private vendors. The school-to-work system is administered jointly by the Education and Labor departments. Obviously, these constituencies have highly distinct priorities regarding funding and program implementation.

A second set of tensions arises because the balance between centrally run services (those directly administered by a government intermediary) and services provided by external contractors is disrupted. Because of the unequal access to centers of political

and policymaking power, government bureaucracies are in a better position to influence program mix and to determine programs that will survive as education and training providers. CBOs may well feel the most adverse impact of the new legislation.

The 1996 bills dealt with these tensions differently. The Senate bill created two block grants, one for at-risk youth ($2.1 billion), the other for workforce education and training ($5.84 billion). The House bill, on the other hand, created three block grants, one each for youth ($2.3 billion), adults ($2.3 billion), and adult education ($280 million). The Senate version also contained fixed proportions for the workforce development component: 25 percent for basic vocational and adult education, 25 percent for employment training, and 50 percent for school-to-work training and economic development activities. The approved House version, ETLEA, continued three block grants targeting the same populations as the previous bill. The Senate version, WIPA, not yet fully approved, has separate titles for vocational education and adult education and training but leaves youth services as part of a more general title on workforce investments and related activities.

Despite the apparent differences in authorizations, it is evident that the new system will be anchored by school-to-work and jobs programs for youth and one-stop centers for the coordination of adult placement, education, and training. And, despite the apparent differences in some key provisions regarding vocational education and governance structures, there is substantial agreement on many core components of the new system.

Key Issues Affecting CBOs

Although it is too early to assess the long-term effects of the proposed legislation on community-based organizations, a few key issues define the parameters of the eventual impact of the new legislation during the initial years of the system's implementation. The combination of the proposed budget cuts and the consolidation of programs is troublesome for two reasons: first, increasing competition will result in politically weaker service providers being less likely to survive, and second, hard-to-serve populations require more specialized and expensive services, which are more likely to be affected by budget cuts. These two tendencies have a direct influence on the ability of CBOs to provide services for the economically and socially disadvantaged. The following section analyzes the effect of the proposed legislation on the traditional role of CBOs in training and education.

CBOs should expect the resulting legislation to limit their eligibility to provide services. Pending legislation proposes that "local educational agencies," such as schools and local boards, will administer the programs serving youth. However, CBOs may be eligible to act as administrative agents for at-risk youth programs. Similarly, both the House and the Senate are likely to target postsecondary educational institutions, particularly community colleges, for adult training funding. The legislation permits the participation of CBOs that meet certain criteria related to program performance and demonstrate effectiveness in serving targeted populations. While it is likely that all organizations certified under Title IV of the Higher Education Act are initially eligible to provide services, CBOs will have to demonstrate minimum completion, placement, and retention rates in order to receive certification. Although there are some differences in the proposed qualifications for service providers, it is clear that the legislation will include strict performance standards. For adults, they are likely to include successful placements, six to twelve months of employment after program completion, and

increased earnings. Youth programs will require a combination of the following performance criteria: acquisition of a high-school or equivalent diploma, reduced dropout rates of participants, and postsecondary education placements.

The employment and training system for adults is further revamped by the consolidation of core services in one-stop centers and the use of vouchers or individual training accounts to regulate other services not provided by these centers. Core services provided by one-stop centers may include assessment, job-search counseling and preparation, employment information, and placement. While the Senate favors the use of vouchers for services not provided by one-stop centers (except in special circumstances when contracting services for special populations), the House leaves the use of vouchers to the discretion of the states. Eligibility to provide services based on vouchers could be limited to organizations that meet the standards established by national or local skill-standard boards.

The legislation is problematic for both CBOs and educational institutions in terms of providing services to the hard to serve. Typically, street-to-work and home-to-work transitions require more support for and the participation of trainees in several programs: for example, mothers may need day care and counseling; former criminal offenders may need psychological help; immigrants may need English-as-a-second-language instruction; and out-of-school youth may need basic skill instruction. Educational institutions are not well prepared to provide the variety of support mechanisms that are typically required to serve these populations. The underlying reason for CBOs to provide integrated services is that they are more specialized and, by implication, more expensive. Are secondary and postsecondary institutions ready to expand their capacity to serve disadvantaged populations? The national trend has universities limiting the number of students in need of remedial education; community colleges are increasingly criticized for not serving the needs of high school graduates with clear deficiencies in basic academic skills; and public school systems have neglected the needs of out-of-school youth.

The proposed governance structure is an area of concern for CBOs. Perhaps the greatest difference between the House and the Senate versions of the legislation is in that area. Although both proposals minimize the role of the federal government and transfer authority to state governments, the House prefers joint oversight and implementation authority with local governments. In 1995, the newsletter for the National Youth Employment Coalition predicted that the reconciliation of the proposed legislation would be delayed because "they may never agree on major differences like the role of the Federal Government and the extent of local decision making. While these bills have been labeled new and improved block grants, the House is still the major advocate for local decision making and the Senate is the champion of Governor's control."[3] The differences implied here refer to the establishment of workforce boards or partnerships, the inclusion of CBOs on those boards, and the new role of the federal government.

One of the clearest signs that Congress will shortly enact workforce development legislation is the compromise implicit in the Employment, Training, and Literacy Enhancement Act. While in 1996 the Workforce Development Act made the establishment of state and local boards optional, the 1997 bill conforms more to the CAREERS provisions establishing both state and local boards. In essence, the House is accepting the transfer of authority to oversee the system to governors, as reiterated by the Senate in WIPA, but requires the establishment of the two types of boards through a collaborative process. Boards or partnerships must have a broad community representation that in-

cludes representatives of the state legislature, local elected officials, key state or city agencies, leaders in business, the education and training field, and others.[4]

Such patterns are troublesome for CBOs because, traditionally, the federal government has been more concerned than local authorities with serving disadvantaged populations. There is vast research documenting how block-grant allocations are influenced by political pressures. Once more, the tension surrounding block-grant implementation stems from the question of how to preserve a focus on serving disadvantaged populations (the function of categorical funding) while increasing program flexibility to adapt to local conditions.

Overall, the proposed legislation provides the opportunity to improve the employment and training system by promoting greater integration of services and linkages to employment opportunities, but it also raises serious concerns about the impact that changes in the service delivery system may have on disadvantaged populations and the organizations that service them. A U.S. Department of Labor study suggests that (1) JTPA, which has been an effective system for those in need of short-term placement services, has had little influence on long-term employability and earnings, given the program's limited impact on skills, and (2) school-to-work programs are an effective framework for linking in-school youth to employment and workplace-based learning opportunities.[5] In particular, one-stop centers, which will get the bulk of placement and information funding, and school-to-work systems are effective in linking the unemployed and youth to employers. It remains to be seen whether these systems will provide effective access to the better job opportunities in regional economies.

Despite the apparent advantages of consolidating services, centralizing information about employment opportunities, and providing outreach to employers, one-stop centers and school-to-work systems have not been designed to serve economically and socially disadvantaged populations. These groups require a combination of services best provided by specially designed programs. The Center for Employment Training (CET) in San Jose, California, Project Quest in San Antonio, Texas, and STRIVE in New York City provide examples of community-based employment training designed to serve the needs of diverse disadvantaged populations. These programs are highly cost-effective, for the benefits to participants and society far exceed their price. However, they are more expensive than conventional programs that do not offer all the support required to serve those in need of more extensive and complex services. Paradoxically, these types of programs may be at greater risk of severe funding cuts and regulatory constraints in the current devolution of federal programs.

Potential Impact on CBOs

A discussion of the potential impact of the proposed employment and training legislation on CBOs illustrates a more general argument about the positive and negative aspects of federal policy reform. The previous discussion suggests that CBOs serving disadvantaged populations will be affected by three key aspects of the new legislation. For discussion purposes, I focus on the effects on CBOs of the following tendencies: a substantial reduction in overall funding for employment training and second-chance education; a change in the mix of services provided; and a change in the operators of such services. These are key components of the legislation likely to be enacted regardless of whether the House or the Senate version prevails.

Although it is not completely clear how extensive the funding cuts will finally be, it *is* clear that even the most optimistic scenario projects reductions of at least 15 percent compared with the previous year's appropriation. However, decreased funding for the types of services currently provided by CBOs and general services to disadvantaged populations are likely to be more substantive because of the lower priority that such programs may be given in the new system and the roles that such government intermediaries as school-to-work programs, one-stop centers, and community colleges are expected to play. Inevitably, these forces will lead to an increase in competition among nongovernmental service providers. In a highly competitive environment, larger institutions with more specialized staffs, for example, in fund-raising, public relations and marketing, and planning and development, are in a better position to respond to policy changes. Thus, size and existing staff capacity alone, regardless of how good or effective they are, may determine which programs will be operating in the next year or two.

A second major change introduced by the legislation is the elimination of categorical funding and the creation of broad programmatic areas for youth and adults. The decision to allocate funding among competing needs is transferred to state and local boards, which must decide on the optimal mix of services. Except in the broad categories previously described and in funding for dislocated workers, state and local boards will have the authority to distribute funding for basic education, vocational and skills training, and complementary programs such as counseling, English-as-a-second-language instruction, job-search assistance, and so forth. The setting of these priorities is not independent of political pressures. Past experience with Community Development Block Grants and JTPA suggests that political priorities often dictate funding priorities and that disadvantaged populations seldom have mechanisms which allow them to participate effectively in that process.

The expected change in service providers is directly related to changes in priorities both in funding and in the mix of services. There is a generalized notion that employment training programs are ineffective. The Department of Labor report, *What's Working (and What's Not),* concludes that very few programs affect the long-term employability and earnings of targeted populations.[6] The new legislation translates that understanding into stricter performance standards for program operators and introduces competition into the decision-making process by mandating vouchers for adult training. At this point, it is not clear whether the same performance criteria will be extended to postsecondary educational institutions. Performance standards for certification and open-market competition are likely to result in the consolidation of service providers into a smaller number of large organizations.

The combined effects of these two expected major outcomes of legislative reform on disadvantaged populations, namely, the centralization of services in mainstream institutions that lack expertise and experience in serving them and the potential demise of many programs serving the community, remain to be seen. But an important variable determining the impact of legislative reform is the ability of community organizations and government intermediaries to respond to the challenges presented by the devolution of federal programs. Before discussing the possible strategies that may be available to key players, it is imperative to review some of the positive aspects of the legislation, the opportunities opened up for CBOs and other intermediaries, and the ability of CBOs to take advantage of such opportunities.

One of the most important aspects of the legislation is its reinforcement of the notion that the new system serves not only workers in need of employment but employers as

well, and perhaps not only *some* employers, but *all* employers. When JTPA was enacted, many CBOs perceived the shift toward greater private-sector participation as a step backward in the employment and training system. Indeed, many experts still believe that the definition of a secondary labor-market, dead-end, low-wage job is "a job listed in the local employment office." The coming legislation may provide the opportunity to strengthen the ties of unemployed workers and disadvantaged populations to the networks deployed by employers to recruit new personnel. There is mounting evidence that training and educational programs which provide such linkages tend to perform better than others in their comparison group. A training system cannot operate appropriately without accounting for *both* disadvantaged populations and employers, that is, without realizing that both sides of the labor market are the beneficiaries of any job-matching program.

A second positive aspect of the legislation is that school-to-work systems and one-stop centers, the government intermediaries which will anchor the new system, are designed to have the core components of a matching system. A true employment training system serves all employers, not only those in search of a contingent labor force. This objective is partly achieved by an orchestrated effort to improve the relevancy of job applicants' skills to employers. Two strategies are particularly appropriate in this regard. First, most workers seeking employment, not just disadvantaged populations, must use the system. And second, employers' ownership of training programs must be promoted by encouraging their participation in setting training priorities and the content of skill training. Pursuit of these strategies by both sides of the labor market will allow government intermediaries to change the current image of workplace education as tracking disadvantaged students to low-paying occupations and the conception of the employment office as a service of last resort.

Introducing performance standards may also provide new opportunities for those serving disadvantaged populations. Current training providers can examine their own record in terms of placement rates and minimum wages to assess whether it is strong enough to ensure certification under the new standards. Since most programs must maintain placement records, most organizations can determine their ability to compete under the new regulations. Critical self-assessment is likely to induce the revamping of current training services. CBOs are starting to study best practice in the industry and to seek partnerships with educational and other training institutions. In many cities, coalitions of training providers are considering the consolidation of functions and greater coordination of services. CBOs have expertise in serving disadvantaged populations and are small enough to be able to respond quickly to changes in funding sources and labor-market conditions, which is their comparative advantage in the current policy environment. This edge will allow them to find training niches — often connected to specific employers — and to strengthen connections to government intermediaries and other training organizations, including postsecondary institutions.

Responses to the Changing Policy Environment

Rather than considering community-based organizations as passive recipients of the legislation, one should consider them as actors engaged in the policymaking process. The most immediate response to the proposed legislation has obviously consisted of efforts to influence Congress regarding its specific components. However, like other actors in the existing education and training system, CBOs have begun a process of

self-assessment and rethinking alliances at the community level. In many ways, communities around the country are engaged in long-range planning that encompasses three types of initiatives: (1) CBOs are examining their capacity and ability to respond to policy challenges; (2) they are seeking to establish partnerships with other organizations to strengthen their ability to continue providing services to their constituencies; and (3) they are organizing broader coalitions to influence policy implementation at the local level.

Since the consolidated block grants transfer authority to the state and local governments, the reaction of CBOs, government intermediaries, and educational institutions to the new policy framework will determine the structure of the new employment training system. Considering how both the one-stop centers and the school-to-work systems have been developed at the state and local levels, it is apparent that there is flexibility in adapting the structure of these intermediaries to local conditions. However, it must be clear to most training providers that these intermediaries are the anchors of the new system and that their own survival will require adapting to this new reality. Although some community organizations may experience an expansion of capacity, most service providers will, at best, maintain existing capacity or, more likely, experience a downsizing of training services.

The reorganization of community-based employment training programs must be based on learning from similar schemes that have achieved high performance standards while serving disadvantaged populations. Among the many good programs throughout the country, the Center for Employment Training and Project Quest have received national recognition as examples of best practice in meeting the needs of hard-to-serve, disadvantaged populations. CET focuses on linking low-skilled workers to good entry-level jobs, while Project Quest supports training for the more technical occupations requiring one or two years of postsecondary education. Both these programs are undergoing replication. The Boston Compact of the Boston public schools, later transformed into the School-to-Career program, is an example of a nationally recognized program assisting in-school students to connect to the workforce as part of their academic learning experience.

The establishment of one-stop centers need not exclude community-based training programs. The First Source Employment Program in Berkeley, California, one of the oldest such referral programs in the country, has been operating since 1986. Like many others that followed, First Source provides local businesses and workers with labor-market information and referrals. CBOs have become partners in training, referrals, placement, and other core operations of the center. About half of all the workers served by the center came through community-based training agencies. Like First Source, Portland Job Net and Westside Industrial Retention and Expansion Network in Cleveland, Ohio, link business development assistance and job training. These intermediaries are funded by the cities in which they are located and by private foundations. They work closely with CBOs, community colleges, churches, and other neighborhood organizations. They have gained national reputations through their high placement rates, their ability to serve a diverse population, and their effectiveness in continually enticing the participation of businesses in the larger regional area.

In sum, best-practice cases of employment and training programs suggest the following strategic directions for community-based and Latino organizations:

1. The development of formal and informal linkages to the emerging government intermediaries anchoring the employment and training system, namely one-stop centers and the school-to-work system.

2. The development of a close relationship with regional employers, particularly those which offer the best possibilities for job growth in the immediate future.

3. The development of linkages to community colleges and other educational institutions that provide technical education to disadvantaged populations.

CBOs that understand the overall direction in which the system is moving will be in a better position to respond to the challenges presented by the revamping of the second-chance employment and training system. Community-based organizations are better prepared to serve disadvantaged populations than government intermediaries or postsecondary educational institutions. One-stop centers cannot provide adequate services for street-to-work or home-to-work transitions; schools have very few programs focusing on out-of-school or at-risk youth; and community colleges have responded very slowly to the challenge of helping those in need of extensive remedial education, counseling, and other support services. Promoting a job and education continuum in which CBOs closely collaborate with government intermediaries, employers, and educational institutions is in everyone's interest. It is also the right thing to do.

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Notes

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2. Steve Savner, *The Implications of Applying Federal Minimum Wage Standards to TANF Work Activities* (Boston: Center for Law and Social Policy, 1997).
3. Alan Zuckerman and Kristina Moore, "Senate and House Move to Conference on Workforce Block Grant," *Youth Notes,* October 1995.
4. The ETLEA received the support of the National Governors Association, the National Conference of State Legislatures, and the National Association of Counties. The U.S. Conference of Mayors withheld its support at the last minute because of differences

over the designation of local workforce areas. The act entitles single unit governments with 500,000 or more population to be local workforce development areas.

5. U.S. Department of Labor, *What's Working (and What's Not): A Summary of Research on the Economic Impacts of Employment and Training Programs* (Washington, D.C.: U.S. Government Printing Office, 1995).
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Improving Workforce Conditions in Private Human Service Agencies

A Partnership between a Union and Human Service Providers

James Green

In 1995 the Service Employees International Union Local 509 and four Massachusetts human service providers signed an unusual agreement to forge a partnership in which employers would remain neutral while the union approached its workers with an offer to advocate in the state legislature for greater funding for private human service employees and to promote cooperative relations with their employers. This study examines the context of the agreement and the pressures on public employee unions and small human service providers whose workforce copes with low wages, high turnover, meager benefits, and poor public image as well as the give-and-take between union and employer representatives and their effort to provide representation for a growing number of poorly paid, often part-time human service workers.

Prologue

At a well-attended press conference held at the Boston Park Plaza Hotel on December 14, 1995, those present heard an announcement of the creation of a new partnership between Local 509 of the Service Employees International Union (SEIU) and several Massachusetts private agencies that offer mental health and retardation services. This revelation heralded a unique development in the history of labor relations. Prior to engaging in collective bargaining, a group of private employers agreed to work with a union to raise incomes for employees and to allow the union to organize the employees without interference. Indeed, the union representatives and providers met frequently and intensively for many months. Both parties engaged in serious discussions without violating the rules set by the National Labor Relations Act, which prohibit actual negotiations prior to the recognition of a duly constituted collective bargaining unit. These discussions bore fruit, producing a format for future bargaining and future contracts between a union and a consortium of employers.

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The proceedings were chaired by Hubie Jones, senior fellow at the John W. McCormack Institute at the University of Massachusetts Boston, who facilitated the meetings of the providers and the union in 1994 and 1995. The event attracted special attention because of the presence of John W. Sweeney, who two months earlier had been elected the new president of the AFL-CIO and had previously, as president of the SEIU, encouraged and promoted Local 509's efforts to create a partnership with the employers. Sweeney described the signing of the agreement as a "historic moment" of "immense importance for the labor movement, for the employer community, for the human service provider community, and for those who believe in the public sector's responsibility for the most unfortunate among us." He said that organized labor was committed to "building bridges" whenever the "shelling stops" and employers cease attacking unions. Now, he declared, some visionary providers had agreed to cease fire and to create "a peace" beneficial to labor and management.

In exchange for employers allowing employees to make a "truly free choice" in a union election without discouragement from management, Local 509 committed itself to forming a new partnership with national backing from SEIU and the AFL-CIO. If employees chose to be represented by SEIU, Sweeney explained, the union would enter into a multiemployer agreement based on a shared commitment to provide highest-quality care for the agencies in the most cost-effective ways. Unions would respect the challenge of providing quality care in such a difficult environment as well as management's right to make necessary decisions; the employers would respect the union's obligation to represent employees. Four agencies and their boards had, in Sweeney's words, made a commitment to their employees and overcome "old-fashioned notions of management prerogatives" to forge a new partnership. Organized labor, always concerned to make unionization pay off for members, wanted to make it pay off for these agencies and for the people they serve.[1]

What brought together a public employee union and some of the private, nonunion employers it was accustomed to fighting at this historic moment? What process allowed a union and representatives of management to overcome the adversarial relations that have prevailed in many workplaces during the past two decades? What are the goals of the partnership for providing quality care, for achieving efficiency and excellence, and for improving the working lives of underpaid, highly transient, direct-care workers? What implications does the partnership hold for public policy, for labor law, and for the process of collective bargaining in the private human service sector? I address these questions through an examination of the contexts in which the partnership was formed and of the forces and motives that brought the parties together and analyze the issues and problems involved and the potential gains to be achieved by all parties in human services.

Contexts

During the 1950s, relatives of patients and human service professionals called for an end to "warehousing" people in large institutions and for the creation of community care facilities. In 1963 Congress made federal funds available to create community-based settings, and in 1966 the Massachusetts Legislature enacted Chapter 735, the Comprehensive Mental Health and Retardation Services Act, which mandated state agencies to create community care facilities and to move people out of the large state institutions. In 1966 the commonwealth of Massachusetts devoted 8 percent of its annual budget to the

care and housing of more than 26,000 people in state mental hospitals and schools for the retarded — the Department of Mental Retardation alone employed 16,000 workers. Deinstitutionalization took place slowly over a period of years and began to reduce the large workforce in state facilities.[2]

Public employee unions, which had originated in some of these institutions, protested the loss of their members' jobs.[3] But these protests did not halt the deinstitutionalization, which enjoyed strong public and government support. The courts ordered community-based facilities to provide alternative but adequate care for deinstitutionalized people. A number of private, mainly nonprofit agencies began to bid on state contracts to provide services for the mentally ill and disabled in community-based, mainly nonunion settings. Some of the providers were former employees of the state-funded agencies that offered such services. Some viewed privatization as an opportunity to apply their ideas for improved treatment and care in settings free of some state regulations and union contract provisions.

During the 1960s and 1970s, deinstitutionalization was largely driven by a concern for the quality of care attainable in large state-run settings and a belief that services delivered through smaller operations located in or near recipients' own neighborhoods would be more humane and more effective. Although implementation of community-based care for the mentally ill and mentally retarded was often limited by inadequate funding, the promise of improved care through deinstitutionalization retained strong support among professionals, recipients, and advocates.

In 1990 Massachusetts governor William Weld established a commission to study the feasibility of closing several of the remaining institutions operated by the state Departments of Mental Health and Mental Retardation. The panel recommended closing nine mental health facilities and public health hospitals over a period of three years, saving the state $144 million initially and $60 million annually. The administration promised to encourage the new private contractors to hire some of the workers employed at the nine institutions. In its first six months in office the Weld administration laid off 3, 000 mental health and retardation workers; it is not clear how many found employment in the private agencies.

For most employees of state institutions, closing the hospitals and state "schools" meant layoffs and uncertainty. For those who sought work in the private sector the change meant a move from large, highly structured workplaces with union pay scales and negotiated labor-management relations to a varied set of working conditions and a new set of employers who often underbid one another for state contracts.

The workers employed by private vendors in the mental health and retardation fields are primarily paraprofessionals who work in group homes or halfway houses as well as in day activity and treatment programs. About 25 percent are professionals who provide treatment such as group therapy and psychotherapy, physical and occupational therapy, and crisis intervention. The majority of the workforce — 65 percent — consists of direct-care workers who help clients eat, bathe, dress, and carry out daily living and working tasks. The remainder consists of clerical and maintenance personnel.

Although some former state employees migrated to the private sector, the privatization of mental health and retardation services has created a new, largely nonunion workforce with lower wages, fewer benefits, more part-time employment, and higher turnover — as high as 66 percent in some agencies, according to some sources.[4] One research report estimates that in about 1,400 Massachusetts private agencies, 60,000 workers, 65 percent female, provide human services, between 18,000 to 25,000 of them

in mental health and mental retardation in 300 agencies. A survey of 125 large vendors reported a force of 84 percent non-Hispanic white workers, 11 percent non-Hispanic black, 3 percent Hispanic, and 1 percent Asian.[5]

Wages and benefits for these private-sector workers are 20 to 40 percent lower than those of the public employees in the field. The starting salary for private direct-care workers is $14,500 compared with $19,450 for public employees. The benefits available to private employees also differ from those of public employees. Indeed, many private agencies that require a thirty-five-hour week for benefit eligibility hire many workers on a less than full-time basis, which makes them ineligible. An estimated 5 to 15 percent of these employees are part-time "relief" workers, and perhaps half the remaining workforce is employed part time for necessary nighttime and evening coverage.[6]

The privately employed human service workers in Massachusetts represent a good example of the national trend toward "contingent" work. The growth of irregular work is characterized by the transformation of the workforce, the decline of real wages and the loss of benefits, instability of employment, and a declining standard of living among the working poor, who are predominantly female and people of color, native born and immigrant. The growth of contingent labor also raises serious public policy questions because many government policies and regulations, for example, the Fair Labor Standards Act, may not cover those who work irregularly.[7] Critics charged that Massachusetts private agencies are not obeying state and federal labor regulations and that some workers are overworked and not paid for their full time.[8]

Massachusetts private providers receive 80 to 100 percent of their budget from state funding. In fiscal year 1993 the Department of Mental Retardation served or supported 25,528 clients in residential, day, and work programs and half the department's budget of $313 million was allocated to private vendors. Wages for Massachusetts direct-care workers in the private sector had been frozen since 1988. Private providers interviewed for this study expressed deep concern over this dilemma and the various negative consequences it creates, like high turnover. They also worried about the lack of benefits, like pensions, as well as training funds and programs for their employees. According to human service professor Elaine Werby, many private providers regarded their funding dilemma as a sign of "disrespect for human service workers" on the part of the legislative and executive branches of state government.[9]

Besides their deep concerns about funding, human service providers expressed anxiety about the managed care trend in government contracting. The Weld administration contracted with one company to provide managed care for all Medicaid mental health clients and human service professionals. Policy analysts, including Dr. Murray Frank of the University of Massachusetts Boston, report that this trend worried many smaller human service providers who feared that larger corporations would bid low, cut costs, and force the smaller agencies to merge or to close their doors.

Labor unions representing human service workers in the public sector strenuously resisted the trend toward privatization, which cost many members their jobs. As one private employer indicated, privatization in Massachusetts did move jobs off the state payroll to eliminate the costs of pensions and wage increases. The resistance to contracting out government services reflected larger efforts by public-sector unions engaged in difficult political battles against tax cuts, budget cuts, and contracting out as well as struggles against public employers' demands for concessions in the bargaining process. A low point for Massachusetts unions came in 1980, when a referendum limiting local property tax rates, Proposition 2½, received an electoral majority. As a result, massive

budget cuts created drastic layoffs of local public servants.[10] Public employee unions were handicapped in their struggle to survive by the consistently unfavorable coverage in the media, which contributed to a lack of public support. A Massachusetts attorney representing human service providers expressed the opinion that public sector unions were simply "unpopular."

The Service Employees International Union, whose locals represented many state human service workers in Massachusetts, met these challenges, first with an effective coalition campaign to defeat a drastic tax-cutting measure put forward in a statewide referendum in 1990. It also opposed privatization with an aggressive public campaign. Sandy Felder, then president of SEIU Local 509, a statewide union representing social work professionals and other human service workers, said her organization did not insist that *only* public service workers could provide services. The local opposed privatization because it led to the "firing of state workers," reducing union membership, and to "the reduction of standards, wages, and benefits for the privatized work force." The local sued the Weld administration to prevent the hiring of laid-off state workers at considerably less pay and benefits. Felder told the *Boston Globe* that "Weld has a vision of selling state government to the lowest bidder without any vision of what sort of services the state should provide." The union also charged that "there was a lot of fraud and lack of oversight" in the private agencies. Local 509 organized a Vendor Waste Watch to point out what it regarded as waste and fraud.[11]

The local energetically supported a bill sponsored by state senator Mark Pacheco, which, when passed over Governor Weld's veto, restricted privatization. The union's aggressive struggle against privatization contributed to what one of the larger providers, Sheldon Bycoff, head of Vinfen Corporation, called a "long-standing history of mistrust" on the part of private agencies and their boards toward Local 509. However, many providers had already opposed unions in principle as well as in practice. Although public-sector unions did organize a few community-based agencies in Massachusetts, they experienced determined opposition from many private human service employers. The Mental Retardation Providers Association issued an advisory strongly opposing unionization, which it believed would "demoralize the workforce through the assessment of dues, the absence of consumer-focused values, and increased opportunities for divisiveness within provider agencies."[12]

Private human service providers and their consultants attended meetings focused on opposing unionization. An attorney retained by Massachusetts providers said that labor relations lawyers received calls from an agency head who said, "I am being organized, I hear there's literature being sent to my work sites . . . and you're gonna help me stop this. You're gonna help me work with middle management and top management around what we can and can't do under the National Labor Relations Board (NLRB) rules and other applicable rules regarding workers' right to organize." One agency director, Chuck Howard, recalled being very "uncomfortable" in the meetings he attended with other directors "to learn how to fight union organizing." He thought the union was addressing real employee concerns. "If there hadn't been so much involved in figuring out how to start and run a nonprofit and manage it and deliver all of the services that were part of it, we probably would have evolved to a more enlightened relationship with our employees."

Public employee unions, in their attempts to organize privatized workers, faced some of the same obstacles as unions in other areas of the economy. Antiunion opposition grew after 1981, when President Reagan broke the air traffic controllers' strike and

terminated union members as federal employees. During the 1980s, employers either violated federal labor law to resist unionization or found ways within the law to discourage it. The NLRB allowed employers to hold "captive meetings" during work hours, issuing antiunion propaganda and intimidating, if not terminating, union supporters and threatening to close up shop if employees chose unions. Even when a majority of workers signed cards authorizing a union election, employers used the intervening period to discourage those who had called for a union. In the 1980s the percentage of union victories in elections declined as did the percentage of eligible workers who belonged to unions.[13]

Like other unions, SEIU faced serious challenges caused by employer opposition, the failure of labor law, a changing workforce, an altered state of labor relations, and a different political climate. Two decades of crisis discredited many of the old methods and gave rise to new ideas about organizing, servicing, bargaining, and cooperating with management. The crisis of the 1980s also provoked a recognition of the need for strategic choices about the campaigns that unions mounted. Unions faced difficult decisions about how to organize new workers, to fight concessions, and to make a maximum impact with fewer resources.[14] This strategic turn is reflected in the AFL-CIO's decision to create and fund a new institute whose goal was to recruit a young cadre of organizers trained in new tactics.

SEIU has been in the forefront of several innovative organizing campaigns directed toward sectors that were difficult to organize. Since many struggles against privatization failed, SEIU debated alternative strategies and decided, after some controversy, to organize privately employed service workers. In so doing, the union drew upon the lessons of the civil rights movement, the women's movement, and community organizations to approach service workers, whose numbers include more women and people of color than the industrial workforce.[15] In the mid-eighties SEIU launched an aggressive drive, Justice for Janitors, among privately employed janitors by regenerating the unions' organizing capacity and devising new tactics aimed at service workers.[16]

Unions organizing service workers and attempting to secure an election supervised by the NLRB faced problems of high turnover, largely attributable to low pay and few chances for advancement. These problems severely handicapped the usual process of organizing a union by obtaining signatures from sufficient numbers of workers to call an election administered by the NLRB. Although any workers in the bargaining unit would ultimately be included in a negotiated union contract, only those employed at the time of the election could vote for certification of the union as bargaining agent. Given the high turnover rate, providers hostile to the union could stall the election with procedural issues, expecting that enough eligible workers would leave their employment to invalidate the NLRB election. Faced with this dilemma, some unions began using a blitz campaign, which puts pressure on an employer to recognize a union as soon as a "card check" indicates that a majority favor unionization.[17]

Proposing a New Model

The 1990 election of Republican William Weld and subsequent drastic reduction of the state's Department of Labor and Industries caused labor unions even more concern about their future. Although the Democrats retained majorities in both houses of the legislature, and the union remained influential with many of those representatives, the

future of public employee unionism seemed most problematic as a result of Weld's efforts to cut taxes and shrink state government. It also became clear to many public employee unions that, even with the Pacheco bill, privatization would continue and that it would be difficult to reverse the process.

In 1993 Sandy Felder and other Local 509 leaders began to focus on the need to organize the workers employed by private contractors. She believed that this task could be accomplished only on a large scale, that it would "be easier to organize the workers if the providers were neutralized," and that the process might involve some "mutual gains bargaining" because, despite the "history of mistrust," the union and provider community shared common needs.

Felder also began discussions with public policy advocates and public officials concerning "the anomalous situation" of privately employed human service workers whose wages were paid by the government but who were largely subjected to private control by employers with little government regulation. She brought this situation to Professor John Dunlop of Harvard University, distinguished labor relations expert, former secretary of labor and chair of President Bill Clinton's Commission on the Future of Worker/Management Relations. Felder described the difficult position of the direct-care workers employed by a myriad of private service agencies, all dependent on the will of the legislature and governor for compensation levels and other employment conditions. She emphasized the problems of privatized workers who are part of a "secondary workforce" that lacked rights under state labor relations and private-sector labor relations governed by federal law. She explained to Dunlop: "When you go to negotiate a contract with the private agencies, they'd say, 'Well, we can't do any more because the state controls our budget.' But then you try to go to the state labor relations, and they'd say, 'Wait. They're a private entity.' So that in the end these workers are getting stuck in the middle." This dilemma created by privatization "intrigued" Dunlop, who asked Felder to testify at the federal government commission hearing he would chair in Boston on January 6, 1994.

Dunlop advised Felder to open discussions of this dilemma with providers and to get a "neutral" to facilitate the dialogue. He also advised her to "keep the lawyers out of the room." During the spring of 1994 Felder began meeting with a number of directors of state-funded, nonprofit agencies, including Joe Leavy of Communities for People, Michael Donham of Center House, and Dan Boynton of Bay Cove Human Services. She advanced her ideas about a cooperative relationship that would help raise the abysmal salary level in the field and provide the union with a chance to approach employees without employer opposition. The union's approach soon became public when Local 509 launched an organizing drive, the Community Care Workers Campaign, to promote a multiemployer partnership based on a new cooperative model of labor relations. The campaign's "deeper purpose" was to create a "seamless web" in the delivery of mental health and mental retardation services in Massachusetts.

In private discussions with providers, the union asked employers to remain neutal and allow the union to contact workers. If the employers remained neutral, the union could help lobby the government to fund increases in their workers' wages. During this concentrated blitz of a few weeks' duration, Local 509 members volunteered to contact nonunion workers and to distribute a questionnaire on working conditions. Only 150 responses were returned, indicating that 82 percent saw no opportunity for career advancement, 75 percent earned less that $20,000 a year, 62 percent received no additional pay for overtime, and 60 percent said they received insufficient training. Employer reactions to the campaign varied. According to one study, most providers "told

their workers not to let the union in" and some "made threats of retaliation."[18]

The particular difficulties of organizing privatized human service workers parallel the obstacles faced by many union organizing drives. Unions that try to organize often face tough opposition from employers who hire antiunion legal and consulting firms. These "union busters" combine hard-hitting practices meant to intimidate union sympathizers in the workforce with complex legal maneuvers meant to wear down the energies of union staff and exhaust union resources. In the late 1970s and 1980s, such union avoidance strategy led to increases in firings for union activities and in more unfair labor practice charges being filed.[19] Not only did antiunion employers actively discourage employees from unionizing, they refused to engage in good faith bargaining for first contracts even after a majority of employees voted to join a union. As a result, unions lost trust in the traditional time-consuming, frustrating process of organizing and bargaining and sought more direct ways of gaining recognition and a first contract.

Given this tradition of employer opposition, Local 509's Community Care Workers Campaign and its outreach to private providers represented a departure from SEIU's past practice of organizing public workers and opposing privatization. Most union activists found it difficult to accept the idea that "the enemy wasn't the providers," that the power was in the hands of the governor and the legislature, and that unionists in Local 509 saw themselves "more as allies with the providers than as enemies." The idea of approaching employers about organizing privatized workers aroused a lively debate within union circles. Some argued that it would violate the National Labor Relations Act's provisions against union bargaining with management before a majority of eligible workers had chosen the union to represent them. In seeking to build relationships with the provider community, Local 509 could not overstep the boundary between establishing a safe organizing environment and conducting contract negotiations before it became the duly constituted bargaining agent. Others thought the idea of persuading human service management to remain neutral was simply naive. Still others felt that the Service Employees International Union had betrayed its members who remained commonwealth employees and that the union would be unable to represent the interests of both sets of workers fairly. However, SEIU national president John Sweeney supported the departure from past practice and encouraged Local 509's initiative.

Concerned with the criticism that unionized public workers are inefficient, Sweeney promoted a new model of public sector unionism, which presents unions as guarantors of quality services. SEIU's Public Division proclaimed a primary goal of enabling "public workers to act as advocates for effective and responsive public service, at work and in the public policy arena." Testifying before a federal commission on the public sector in 1994, Sweeney argued that the achievement of excellence in public service would require "meaningful worker participation in all levels of decision making concerning the design and delivery of public service."[20]

Addressing the growth of nonunion workers doing public work through private employers, Sweeney asserted that cooperation would be impossible without protection afforded to workers who would fear reprisals if they challenged or questioned management decisions. "When employees are afforded the necessary assurances and protections, they typically welcome the opportunity to work with management to achieve greater efficiency in government." Ultimately, Sweeney maintained, the public would benefit from reducing the differential between low wages and poor benefits in the private service and the public sector. He also suggested that without an expanded scope of collective bargaining, genuine labor-management cooperation would not be possible. Subjects like

agency mission, not usually subjects of bargaining, would have to be put on the table so that employees are "true partners" with managers.[21]

It is increasingly common for unions and management to participate in joint committees around workplace issues. It is also increasingly common for employers at non-unionized firms to establish vehicles for worker participation in some kinds of decision making. Some union and academic critics argue that these forms of participation are deceptive efforts to give employees a sense of involvement that will stave off unionization efforts. Employer-initiated efforts have become controversial since they risk violating the National Labor Relations Act prohibition on "company unions," including employer-dominated committees.[22]

However, in the industrial-union sector organizations like the United Auto Wokers have entered joint decision-making programs with management; and some public-sector unions have supported joint labor-management committees to devise ways of providing better, more cost-effective services as an alternative to privatization. Many unions propose union participation in management as a way of addressing a number of problems: increasing quality of care, consumer satisfaction, and public support; reducing conflict and adversarial union-management relations in workplaces as well as improving training and reducing turnover in the workforce.[23]

Powerful motivations led President Felder to reach out to providers who might be interested in a new model of labor-management relations in the human services. She was aware of public policy analysts who argued that the growth of part-time or contingent labor required a change in union strategies as well as public policies. One study urged unions to reevaluate their antagonism toward nontraditional forms of employment and to focus instead on combining innovative collective bargaining with public policies that "can control employer abuses of part-time and contingent work arrangement, extend the benefit of flexibility to as wide a group as possible, and supplement employer-provided fringe benefits — even though these policies may make unions appear less necessary."[24]

From the providers' side, strong opposition to unions remained, but some were willing to talk to the union representatives, especially those who were heavily dependent on state contracts and were frustrated by the wage freeze for direct-care workers. Tom Riley, executive director of Better Community Living in New Bedford, felt that the legislative committee on human services lacked trust in the providers to spend funds appropriately. This was reflected in the budget freeze after 1988. Then in 1993, when a budget increase did not even get out of a conference committee, a red flag went up, and Riley became even more concerned about the "political process" involved in budgeting. He began attending the McCormack Institute Forum meetings with Local 509 after he received calls from people in his community, including legislators, encouraging him to participate. He had begun working in the field at a time when staff salary increases came regularly but during the long budget freeze he realized that his staff would not be able to increase their pay without "as much public support as the agencies could possibly get." "I looked on the horizon and I didn't see a lot of people . . . willing to support our agency," he added, "but the union was knocking on the door and I said come on in" and talk to staff. Used to dealing with unionized public servants as a member of his local school committee, Riley thought that collective bargaining might give legislators more confidence that budget increases would actually go to the direct-care workers and "be assured that it's not going to be misspent." He thought the union might be able to make the whole budgeting process and the process of wage determination more "reasonable."

Sandy Felder's argument on behalf of the union addressed the providers' concern with elevating wages and the legislature's concern that additional funds might not be spent on direct-care workers. In the long run, she hoped, the legislature would see that it makes sense to take responsibility for the privatized workforce in mental health and mental retardation. Contracting out the services would not absolve government of its responsibility to the workforce and the clients. "Wouldn't it be better," she asked, "to have some standards and some knowledge of how much money" these workers will receive instead of "just throwing money out to providers" who can spend it any way they choose? The legislature needed a systematic way of getting the money out there to the workers through the agencies, she maintained. "And why not have that systematic way come through collective bargaining?" With a contract the government would have the union make sure the funding ended up in the pay of direct-care workers, thus giving the government more control over its spending on these programs.

Besides organizing a more powerful lobbying group and creating a better system for the state to pay direct-care workers, the union saw another advantage in a multiemployer agreement. The geographical dispersion of 300 agencies created problems for the union in terms of organizing, bargaining, and staffing. For Local 509, organizing had to proceed on an agency-by-agency basis, but the union hoped for a master contract that would bring all, or at least many, agencies under one umbrella. The preference for a multiemployer bargaining process shaped the union's approach from the beginning. The multiemployer framework was seen not only as a way to streamline contract administration; it could also achieve certain economies of scale. "The idea," said Felder, "was to bring them together collectively and to amass their power as one group of providers, so that we then [could] go to lobby to get funding or get them to share health insurance or workers' compensation or training. . . . If they come together in a multiemployer agreement, they can share things as well. So we felt that would be an added . . . value to the workers of the agency."

Seeking to escape the old adversarial model without abandoning a commitment to aggressive organizing, President Felder decided to reach out publicly to private providers to seek a partnership. Based on her conversations with providers, the support of President Sweeney, and Professor Dunlop's advice, Felder looked for someone to convene a meeting of unions and providers. She thought the union would need someone it could trust but also "someone of stature who could bring providers to the table with us."

Negotiating a New Partnership

After preliminary discussions with providers, Felder and others agreed that Hubie Jones was the best choice to facilitate a process of dialogue. The former dean of the School of Social Work at Boston University and an influential voice in political affairs, Jones enjoyed the authority and respect required to bring together diverse parties in the human service world. As senior fellow at the John W. McCormack Institute of Public Affairs at the University of Massachusetts Boston, he maintained a strong interest in human services and public policy. After consideration of Felder's request for assistance in working with the provider community, Jones offered to conduct a forum under the sponsorship of the McCormack Institute beginning in the fall of 1994. If the first meeting was a success, he would plan more gatherings. For many providers the setting at the University of Massachusetts in Boston offered a neutral ground where issues could be explored with civility and caution.

Jones sought the assistance of two other institute fellows, Dr. Elaine Werby and Dr. Murray Frank. Werby and Frank also had distinguished careers in human services as administrators and teachers and both had been affiliated with the University of Massachusetts Boston's College of Public and Community Service, a school that educates human service workers and labor leaders. Werby was a professor in the Human Services Center and Frank was the dean, a position he assumed after working for public employee unions in New York. The institute fellows played important facilitating and mediating roles in an unprecedented process of bringing together institutional actors dedicated to the well-being of their constituencies, yet potentially and actually in conflict with each other. According to Frank, who chaired many meetings, this was an appropriate role for a public university with a service mission and an urban agenda.

Frank and Werby both emphasized the unique quality of the dialogue they facilitated. The parties had no experience of coming together outside the labor-management framework and both sides harbored strong feelings about "the other side." Both parties took considerable risks in getting to the table. Indeed, the providers who participated did so without the support of their boards of directors, whose members usually opposed unions strenuously; they even faced, as Frank put it, a degree of scorn from other directors and peers in their field.

The union's energetic efforts to invite providers from across the state to these meetings, along with 509's ongoing organizing drive, brought the issue of unionization to the forefront among the providers themselves. According to Boyce Slayman, executive director of the Massachusetts Council of Human Service Providers, the council was beset by two opposing points of view. Some members wanted to endorse the process of exploration under way at the McCormack Institute to see if it would "result in getting workers more money" and to see if the new model the union proposed would work. Some wanted the council to oppose the union. As Slayman explained, "In some cases providers had been unionized before, but the members had voted them out," while in others, which had not been unionized, managers and board members believed "that unions invest tremendous resources in keeping bad workers on the job." Furthermore, these antiunion pro-viders refused "to submit to any more rules and regulations than . . . absolutely necessary."

The McCormack Institute Forum "The Future of the Human Services Workforce" was announced in a mailing to a wide variety of interested parties, including providers in the mental heath and retardation field, public officials, and academics. The forum organizers were surprised to find approximately thirty agencies represented at the meetings in the fall of 1994 and through the winter and spring of 1995.

Their motivations varied. Many of the providers in attendance shared a concern over the budget freeze and the low wage level of their direct-care workers. Some, like Chuck Howard of Cooperative Human Services, had lost confidence in the capacity of providers "to lobby the legislature to get funding." Some providers who expressed interest believed their competitors were underbidding them for state contracts by paying lower wages. The union clearly appealed to the providers to create a common standard on wages, and to take wages out of competition. Some, as Hubie Jones suggested, were concerned that the union's organizing drive would lead to conflicts that would harm their agencies. One executive director, Larry Urban of the Renaissance Club in Lowell, knew that ten of his workers had expressed interest in unionizing after making contact with organizers from SEIU Local 509. Unlike many employers, he was not worried about the presence of the union organizers in the workplace because "our door has been wide

open" for a discussion of any new programs or ideas. "It was not something I felt was an intrusion, but just part of the open decision-making process that . . . has always gone on here."

Urban was concerned, however, about the implications of unionization for "the overall operation of the agency." Since organizing was already going on among direct-care workers in his area, he decided to attend the first meeting at the McCormack Institute to find out what it was "all about" and to discuss a partnership that would not be based on the "traditional model" of adversarial relations in which employers are "compelled to come to the table" by the union. Urban hoped the new-model partnership could have a positive goal of "empowering workers" through improved training and programs to allow them to cooperate more effectively with employers who would have an added advantage of participating in a multiemployer organization that would benefit all partners.

The response to the first meeting of the Human Services Workforce Forum on November 16, 1994, was encouraging to the sponsors. The approximately thirty providers who attended heard a number of presentations, including one by Philip Johnston, regional director of the federal Department of Health and Human Services, and former secretary of human services for Massachusetts. He articulated the widely held view that the low salary levels of direct-care workers in the field had caused a major crisis for human service agencies and their clients.

Jones thought that "the first meeting went very well" because there was "straight talk from human service providers" who had felt burned by "some union tactics and behavior." Providers expressed their concerns over the union's campaigns against privatization, its efforts to expose contractor abuses, and what some employers believed to be the protection of incompetent workers under union contracts. But they also made it clear, said Jones, that "if they didn't work out some collaborative way of embracing each other, they were going to kill each other off." Furthermore, "they weren't going to get anywhere with the legislature in terms of getting more money."

A summary of the first meeting listed the following issues as the main topics of discussion: first, the hostile political climate for providers and workers alike; second, the efforts of the governor to pit state workers against privatized workers; third, the negative publicity generated by hostile infighting among human service interest groups; fourth, the level of funding of mental health and retardation budgets leading to lower wages, fewer benefits, higher turnover, and low morale.

The meeting reached a decision that the infighting within human services had to stop and that "the only way to increase fiscal and political support, and improve working conditions, is to organize a new model of provider-worker cooperation." One model proposed by Local 509 was that the union represent all private workers and negotiate one contract on their behalf, which would also increase the bargaining power of the union with the state legislature and allow providers to organize together more effectively. The main problem with such a model was that it required trust from both sides, and some providers expressed the view that collective bargaining was adversarial by nature and promoted distrust; thinking that conflict might produce strikes, they wanted no-strike clauses; they also believed unions defended workers "to the hilt" in grievance procedures and placed management at a disadvantage. The providers' concern that union contracts and grievance procedures protected incompetent or abusive workers surfaced as a serious issue and would remain so.

Over the course of this meeting and those that followed, the union's representatives

offered their new model of labor-management cooperation and pledged their formidable political influence to the campaign to raise wages. The union expressed deep concern with providers who made serious efforts to dissuade their employees from joining unions; therefore, Service Employees International Union participants wanted to know whether employers would enter an agreement to remain neutral while the union approached employees, allowing them to choose for themselves.

The mood created by the forum in the fall of 1994 encouraged hopes that the process could move from tentative overtures to real commitments. Jones extended an invitation to use the McCormack Institute as a meeting venue and offered to broaden the efforts he, Frank, and Werby were making to facilitate the process.

The forum decided to create two subcommittees, one to work on a model agreement and the other to focus on a strategy to lobby the legislature for the first increase in Mental Health and Mental Retardation funding in seven years. However, disagreement between the union and the providers led to the dissolution of the second subcommittee, and the union pursued its own course in lobbying for the increase during the spring of 1995. The union and the providers engaged in separate lobbying to increase funding for human service employees. The overall effort, which joined that of human service advocacy groups, led to an important public policy debate on the consequences of deinstitutionalization and privatization.

In 1993 the administration of Governor William Weld issued a report praising the "dramatic savings" resulting from the privatization of human services. Yet the privatized workers who staffed deinstitutionalized, privatized services still suffered from frozen wages. Emphasizing this paradox, human service advocates convinced the governor to support an increase in funding directly targeted to wages for direct-care staff in residential programs. Weld recommended a $15 million increase in compensation for these workers in his proposed budget for fiscal 1996 but did not lobby for it.

When the House Ways and Means Committee cut the increase from the budget, the public policy debate took place very briefly. Committee chairman Representative Thomas Finneran argued that the legislature could not earmark funding for privately run agencies working under state contracts because it would "cross a line" between public funding and public control; in effect, such a provision would violate private owners' rights to determine wage levels for their employees. Responding to the cut, the *Boston Globe* editorialized the following day that "modest raises for these workers are essential if the state departments of Mental Health and Mental Retardation are serious about providing quality care in humane settings, the goal of institutionalization." Rejecting Finneran's view that public financing of human services did not permit public decision making about working conditions, the *Globe* editorial maintained: "The state, the sole buyer of these services, cannot escape accountability just because workers are employed by nonprofit agencies."[25] This view mirrored that of the union and those private providers who lobbied for an increase in wages for direct-care workers.

In any case, an important public policy question had been raised and debated: in an era of entrepreneurial government, namely, Will public funding decisions include policies and practices that affect the workforce, and will private employers who contract with the state be accountable to government as the ultimate employer?

An existing public policy requires the state to set wages for private employees on state and federal construction projects where the "prevailing wage" rate and other labor regulations are required. Some public policy advocates concerned about the expansion of low-wage jobs in the service sector, including the human service sector, have urged

the Clinton administration to develop a new social contract that would include these workers just as the Roosevelt administration created a social contract with private-sector employers and unionized industrial workers in the New Deal era.[26]

The idea of joint lobbying remained an important part of the union's case for creating a new partnership and for extending the precedent of minimum wage and prevailing wage laws to the privately employed human service workforce. Sandy Felder believed that the legislature might look more favorably on a salary increase for direct-care workers if labor and management presented a united front.

As the forum discussions continued, the word spread rapidly throughout the human service world and, according to Hubie Jones, providers kept well informed on the discussions. Ultimately, "the human service providers of power and substance" would need to be part of a successful partnership, but their absence did not discredit the process. They knew what was going on at the table, Jones explained. "We had their attention even though they were not there in the room."

On two occasions, the Massachusetts Council of Human Services Providers' newspaper carried front page reports of the McCormack Forum, which led some members to criticize council director Boyce Slayman for giving the union too prominent a place in council affairs. According to Slayman, one group wanted the council to "take a very clear, firm antiunion posture," but there was another group who wanted "the council to explore and investigate."

During the early months of 1995 the forum discussion led to substantial work in drafting the basis for a cooperative agreement or partnership. A Model Committee developed a document that set out issues to be addressed in contract negotiations. Once some providers became convinced that the union could indeed "add value" to their workplace, they wanted to forge ahead to contract negotiations. However, the union was careful not to undertake any actual bargaining in advance of recognition by the workers. It did, however, orient the providers about the negotiation process and discuss what kinds of topics could be brought up in bargaining.

The Model Committee's first draft agreement included eight principles intended to be the basis of an agreement that private providers would be asked to sign. It pledged that the parties engaged in developing the agreement would not "publicly attack each other" during the process, nor would the union publicize the participation of any agency in the process or single out any participating agency for an unusual effort to organize its employees. A critical point, number 5, required that providers not take a position on the issue of unionization so that its employees could "form their own opinions, pro or con, free from fear of retaliation. Point number. 6 allowed for any party to terminate the agreement at any time with notice to the other." That first draft, facilitator Elaine Werby recalled, afforded the parties a chance to learn how to talk to one another and how to handle the most controversial issues.

The Model Committee moved ahead and produced another draft document in April. At this point, Werby pointed out, some of the wrangling over formal, legal issues receded as an atmosphere of greater respect and trust emerged. This draft proposed a consortium of providers who would sign an agreement to cooperate with the union and with each other on a whole range of issues. This fascinating document took another approach to the key question of employer neutrality during the unions' organizing efforts. The proposed language stated that employers would regard union organizing "with the same spirit of neutrality in which the present providers participate [that is, in the Human Services Workforce Forum]."

The proposed agreement addressed some difficult issues raised by federal labor law about the process of labor-management cooperation prior to the actual signing of a collective bargaining agreement. The draft indicated that nothing in the cooperative arrangement, especially specific terms of wages, hours, work rules, and so forth, could be negotiated until workers voted for representation by a union.

The proposed model agreement identified those issues to be "jointly decided" by management and labor and clarified the prerogatives of each party. It recommended worker participation in decision making at the agency level, and "client involvement in decision making about workplace issues." The document also proposed a provider/union training and recruitment fund. In addition, it identified management rights, including "business decisions" such as expansion and contraction, standard for intake of clients, codes of ethics and behavior, and "all practices not specifically identified in consortium agreements." One employer's expression of great concern about the right to discipline, suspend, or terminate employees provoked much discussion; providers complained that unions defended all grievants, including taking cases to costly arbitration hearings. The proposed agreement reflected the union's willingness to engage in new approaches to "fair problem solving," which allowed for alternatives to the "standard contractual grievance procedure." Indeed, the parties envisioned recourse to such a procedure "only if the agreed-to procedure has not been fulfilled." Facilitator Murray Frank believed that this was a crucial sign of flexibility on the part of the union.

The agreement established terms under which the union could contact workers at the participating agencies without opposition or harassment by agency management or board of directors. Significantly, the agreement required providers to recognize the union if a majority of workers elected to join by signing cards. To avoid the long delay between the organization drive and the official election of union representation, the agreement included card-check certification. Workers would sign cards indicating their choice of Local 509 as bargaining agent, and the cards would be held and counted by a neutral third party that would follow agreed-on procedures to validate and tabulate the signatures. The Catholic Labor Guild in Boston, which has promoted union education and labor-management cooperation for decades, was chosen to fill this role. (The guild often conducts union elections and card checks as an alternative to the NLRB.) If a majority of workers signed cards, the parties agreed to negotiate a multiemployer contract, thus avoiding the common problem of employers' refusal to negotiate a first contract.

Once the Model Committee completed its report, the next step was to move into the recognition process. Five provider agencies initially decided to go forward. One soon dropped out because its director became seriously ill and no replacement was sent to this group. The four who continued to meet into the fall of 1995 were Michael Haran, executive director of the Cambridge and Somerville Cooperative Apartment Project (CASCAP), Cambridge; Chuck Howard, executive director of Cooperative Human Services, Malden; Tom Riley, executive director of Better Community Living, New Bedford; and Larry Urban, executive director of the Renaissance Club, Lowell.

During the fall the providers who remained in the process decided to retain a lawyer to help formulate their position. Attorney Frederick Misilo had served as assistant and deputy commissioner of the Department of Mental Retardation and as the executive director of a unionized human service agency. He represented a number of nonunion providers opposed to collaboration with the union, but he was quite open to the notion of facilitating a partnership with Local 509 and interested providers. Beginning in early

September, Misilo began offering the active providers legal counsel on "reaching some sort of an agreement regarding how to allow SEIU to communicate with their employees."

To Misilo the proposed partnership seemed to hold out the promise that workers could stay in the mental health and retardation fields and do good work, "to view working with people with disabilities as a career," not as "transitional" employment. For this to happen, working conditions and economic benefits would have to be "significant enough" to attract workers to the field as a career. Until Misilo became involved, the providers lacked the ability to negotiate with the union as a unified group. During the fall, they, like the union, formed a united front, and discussions moved to the negotiation stage more quickly under the guidance of mediator David Matz, a University of Massachusetts Boston professor who directs the graduate program in dispute resolution.

The dialogue focused on a number of outstanding issues, including the welfare of consumers in a future partnership. The agency directors emphasized the importance of a workforce responsive to particular and constantly evolving needs and circumstances that consumers present through different phases of development in their lives, relationships, and skills. In many cases boundaries are blurred — consumers in some cases do paid work for the service provider and are eligible for union membership; some consumers live with foster families who are compensated for their expenses, while others live in group homes with staff that changes with every shift or is only on site at certain times to assist with certain activities like cooking or shopping. Consumers often need care tailored to their particular needs, so both workers and providers face a major challenge in meeting those needs, offering them an exciting opportunity to exercise creativity and insight.

Several providers make conscious efforts to involve consumers in decision-making processes ranging from choice of everyday activities to agency governance. The providers' attorney expressed the concern as follows: "The consumer should be at the table with the employers and employees in the negotiating process." The interest of the consumers should "serve as a focal point to the definition of the employer-employee relationship." This is "what brings the employer and employee together," unlike an "auto factory where the goal is to make a machine." If, Misilo maintained, the interaction between employee and the consumer "is dominated by the employees' concerns and all the things that are traditionally part of a collective bargaining agreement, then the consumer is potentially shortchanged." He added, however, that a previous agreement reached between the state and the employees' alliance recognized that consumers "have an important and vital part to play in the negotiation process and the collective bargaining agreement."

Sandy Felder, having been part of the state labor negotiations that empowered consumers, argued that consumer interests could be protected in a collective bargaining framework. She and other union participants in the process emphasized their respect for the needs of consumers and their families and the desire of these people for control over significant aspects of their own lives. The rights the unions achieve for workers should not negate consumers' rights, according to Felder. She believes that consumers should have input into hiring and assignments as long as the worker has due process in personnel actions like discipline and termination.

Although some of these larger issues remained unresolved, the parties moved in November toward an agreement based on the April Model Committee Report. Four providers signed the final version of the partnership agreement on December 14, 1995.

To John Sweeney, the president of SEIU, newly elected to the presidency of the national AFL-CIO on a reform program, the creation of a new partnership signified a new environment for cooperation in which a "mutually beneficial peace can grow." Edward Malloy, who succeeded Sandy Felder as president of Local 509, offered his support and emphasized the precedence of the agreement that "allows workers to decide whether they want to unionize without any influence from their employer."

Consequences

In January 1996, SEIU Local 509, with financial support from the international union, sent out organizers to contact the employees of the four providers who had formally agreed to remain neutral. The December agreement provided for access to workers by union representatives on nonwork time, but when the organizing drive began, negotiations were required to sort out what access would mean. One agency did not allow union organizers in the group homes during breaks, arguing that consumer privacy would be violated. In any case, the union gained access to work either through the workplace or home visits. In February a sizable majority of workers signed cards requesting representation by SEIU and another group in a third agency followed suit in April. However, difficulties ensued in CASCAP as the union accused the director of failing to honor the neutrality provision of the December agreement. The union petitioned for an NLRB election at CASCAP, and on May 10, 1996, the union prevailed by a single vote.

That month Michael Gallagher, the SEIU staff person consistently involved in the 1995 negotiations, submitted a grant to the Federal Mediation and Conciliation Service (FMCS) to fund the partnership and provide staff for the consortium to facilitate cooperation between labor and management. Negotiations between the union and the four providers began in the summer of 1996, with the grant proposal designed in part to help facilitate the process and promote "interest-based bargaining" — a more cooperative approach to bargaining — instead of "position-based bargaining" — the adversarial approach in which each party begins negotiations with a list of explicit demands. In October 1996 the partnership received the grant from the FMCS and in 1997 hired staff persons to facilitate the cooperative work.

The formal negotiations between the union and the providers have not yet produced a master agreement. It has been difficult to agree on a common set of wage provisions for agencies with different workforces located in different parts of the state and with different funding sources and vastly different wage scales determined by local labor markets. Without the participation of many more agencies and employees, bargainers have been unable to realize the economies of scale first envisioned. Even pooling the costs of employee benefits has been difficult because insurance rates vary from one area to another.

What are the prospects for extending the partnership forged in 1995? Boyce Slayman of the Providers' Council is sympathetic to the need of the workforce for adequate compensation, benefits, and good working conditions, but he said that many providers reject the way they think unions conduct business. Many want to wait to see the outcome of the union's innovations in labor-management relations. Slayman believes the discussions of a "new model," a "non-aggression pact," means "just laying down the weapons, not fighting." But he is still not sure that the agreement is "truly a new kind of partnership." The Service Employees International Union has traditionally represented

state workers and, he said, "there is no history of the SEIU expressing concern for the what Boyce Slayman called "the providers' fears that ultimately there will be more energy spent on grievance processes for bad employees than there will be on innovative models of care delivery." Chuck Howard agrees that the union has had difficulty selling its new model to agency managers who believe that a labor contract will prevent them from getting rid of "people who abuse people or don't treat them with respect." This, he thinks, is the union's main liability. The employers can help the union, but it has "to shed that skin" in order for the process to move on. Howard remained active in the forum after some providers left because he saw real possibilities of labor-management cooperation in other sectors of the economy, which allowed both employers and unions to improve.

The future of the partnership and its approach to new providers depends, among other things, on addressing the problem of discipline and termination in the workplace — to put it negatively — and staff development and improvement — to put the issue positively. Ultimately, both labor and management agree that the human service field offers a chance to create a new, less adversarial model of labor relations. Mediator David Matz argued that providers should accept the inevitability of conflict in the workplace and seek effective means of resolving disputes over employee performance. SEIU spokesperson Nancy Mills agreed and offered to present "ten different examples" of how contracts could be written to enhance flexibility and accountability, improve performance, and allow for just-cause terminations. "We can devise processes that don't put the union in the position of defending the worst, but we're concerned about fairness and due process." In most union contracts a just-cause principle strikes a balance between the interests of management and labor because such a clause can be used to hold "management to a high standard of consistency" and to avoid arbitrary terminations and punishments. The old model of labor conflict over discipline and discharge cases could be transcended, Mills maintained, but those innovations would have to be "joint solutions" emerging from real contract negotiations.

The providers' legal counsel, Frederick Misilo, thinks the big question ahead lies with the other employers, like those he represents who are still "zealously opposed to collaboration." But if the focus turns to workforce development, he thinks there are opportunities for cooperation even though public employee unions are still not popular. "There is a great deal of insecurity" among human service workers. "This large workforce out there . . . does not have pensions and [is] not in a large enough pool to buy long-term insurance," he adds. "People who are working in . . . human services shouldn't be forced into poverty."

Larry Urban hoped a partnership could improve "the identity of the whole human services field." There are some 1,200 providers whose identity as a group is not well defined in the public's mind. And, he adds, there is the lingering "stigma" attached by the public to those who worked in the field of mental illness and mental retardation. So a partnership with the union "may provide a vehicle for finally making some real impact on the public and legislative perception of what human services are all about" as well as "providing some base for the funding of these programs."

SEIU Local 509 followed through with its commitment to seek salary increases for direct-care workers in private agencies, even though very few of those workers belonged to the union. In 1995 its efforts in the legislature focused on creating an enforceable minimum wage for direct-care workers. The legislature ordered a study of the wage rates in the industry, which appeared in January 1996 and recommended a $12 million

increase in compensation for direct-care workers earning less than $20,000 per year. The governor proposed this increase in his budget, and thousands of direct-care workers received a 4 percent raise. The union had helped to raise the issue of compensation for privately employed direct-care workers' wage in the legislature. Eileen Haggerty, the director of the SEIU Community Care Workers Campaign, believes the legislative campaign made this group of neglected employees far more visible to lawmakers. In her view, the traditional lobbying by the providers aimed at increasing human service funding without explicitly identifying the needs of the workers. Minimum wage laws are, of course, traditionally supported by organized labor, notably in Massachusetts, where the legislature increased the minimum wage in 1996 over the governor's veto. However, the legislative campaign for direct-care workers represents a risk for SEIU Local 509, namely, that the workers who receive wage increases through legislation will be less responsive to the union's case that workers need collective bargaining and union representation to improve their situation.

It is too early to know whether the Service Employees International Union will benefit from the legislative approach to wage improvement. Indeed, it is too soon to tell whether the Partnership for Quality Care will be able to create a lasting multiemployer agreement with a union or whether that approach will draw other providers into a relationship with the union. Resistance to unionism remains strong among many agency heads. In New Bedford, for example, where SEIU Local 509 has been organizing human services agencies, the union filed numerous unfair labor practice charges against one employer that was held responsible for illegal labor practices by the National Labor Relations Board.

Whatever the fate of the experimental model proposed by SEIU Local 509, workforce problems will increase in the privatized human services, especially as it is affected by cost cutting and other practices required by managed care. The head of the largest private human service agency in Massachusetts, a strong foe of unions, has argued that cost savings are essential to the health of the industry, which should embrace managed care.[27]

The managed care trend is supposed to increase consumer choice and lower costs, but it also drastically affects the quality of care provided by human service workers and the conditions under which they provide that care. Pressure to degrade professionals, de-skill occupations, reduce benefits, and expand part-time employment will no doubt be accelerated by managed care as part of the drive to cut costs and increase productivity. There is some movement toward unionization of doctors and other employees of health maintenance organizations affected adversely by cost cutting and other results of managed care. Doctors who are employees rather than private practitioners have increased from 24 percent of the medical profession to an estimated 42 percent; some of these physicians are choosing union representation and collective bargaining because they are frustrated "at their loss of decision making" and from new demands like "gag rules that restrict what doctors can tell patients about treatments to the practice of releasing patients hours after surgery."[28]

Similar responses to managed care are appearing in human service agencies. Representatives of SEIU Local 509 have been emphasizing the problems of human service workers' facing the impact of managed care. In March 1996 the union was approached by a group of human service professionals who were discontented with the pressures caused by managed care. The clinicians at the Tri-City agency in Medford, Massachusetts, led an effort to unionize, and a year later a majority of the agency's 270 employees chose

SEIU Local 509 in an election supervised by the NLRB. This is a traditional example of one group of employees organizing one employer and then negotiating its own contract, which may involve a historic adversarial relationship between workers and employers. Unions like Local 509 will continue to represent workers in these situations, but it is unlikely that the bulk of the growing low-wage workforce in the human service industry will be represented as a result of organizing and bargaining based on single units or agencies.

The partnership created by SEIU Local 509 and four providers attempted a different, cooperative route. It seems unlikely, however, that this new model can survive and expand without supportive public policies. In 1933 federal labor legislation, the National Industrial Recovery Act, demonstrated how public policies could be developed to provide codes affecting minimum wage rates and conditions of employment so that small employers were not forced to keep wages low and reduce benefits in order to remain competitive. When the Supreme Court ruled the NIRA unconstitutional in 1935, Congress enacted the National Labor Relations Act to provide federal support for union representation and collective bargaining for private employees. And in 1936 Congress adopted a public policy based on the principle that private employers receiving public revenues could be regulated by the government: the Walsh-Healey Public Contracts Act (sponsored by a senator and a congressman from Massachusetts) extended federal regulations, including hours and other terms of employment, to employees working on government contracts.

Like the New Deal federal labor policies, public policies at the state level could promote collective bargaining and interest-based negotiations by ensuring that workers have a chance to be represented. For example, in the spring of 1997, SEIU Local 509 filed a bill in the Massachusetts Legislature to remove any disadvantage in bidding for state contracts from employers engaged in collective bargaining with their employees. The bill — House 2118, Senate 587— also proposed increased pay for longevity, to decrease turnover, and better pay for night-shift workers.

But public policies could do more than regulate wages; they could promote workforce development by encouraging the creation of joint efforts to solve workplace problems, to improve employee training, to ensure employee stability, to advance quality care, and to promote the importance and public appreciation of the human services and the workers who provide those services. This study of a labor-management partnership suggests that more can be done to advance the general welfare of the human service workforce with union involvement than has been done without it. If policy-makers act on the assumption that the quality of care will increase only if the quality of work life increases in human service agencies, the partnership described here could well be a prototype for future government-sponsored collaboration. Although many workers in the human service workforce are employed by private agencies, its funding is largely drawn from public revenues distributed by the government. It is therefore legitimate for public policies to shape and regulate the conditions under which that workforce can be fully trained, adequately supported, and fairly compensated.

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Notes

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3. On the unionization , see Tom Juravich, William H. Hartford, and James R. Green, *Commonwealth of Toil: Chapters from the Story of Massachusetts Workers and Their Unions* (Amherst: University of Massachusetts Press, 1996), 139–145 .
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9. All quotations were excerpted from transcripts of interviews conducted by Laurie Dougherty, which are on file at the Labor Resource Center, University of Massachusetts Boston.
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Robert Frost, "The Gift Outright," in *The Poetry of Robert Frost,* edited by Edward Connery Lathem (New York: Holt, Rinehart and Winston, 1975), 348.
Richard E. Neustadt, *Presidential Power* (New York: Wiley, 1960), 24.

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Shaun O'Connell, "The Infrequent Family: In Search of Boston's Literary Community," *Boston Magazine* 67, no. 1 (January 1975): 44–47.

5. The journal uses shortened references rather than op. cit. For a book, include last name(s) of author(s); short title containing key word(s) of main title; and page number(s) of reference. For a periodical article, include last name(s) of author(s); short title of article; and page number(s). For example:

Frost, "The Gift Outright," 348.
Neustadt, *Presidential Power,* 24.
O'Connell, "Infrequent Family," 44–47.

6. We are happy to answer any questions about these guidelines. Address queries and manuscripts to:

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